2008 Comprehensive Performance Report:
Commercial HMO, POS, and PPO Plans in Maryland

MARYLAND
HEALTH CARE
COMMISSION

Maryland Health Care Commission

The Maryland Health Care Commission (MHCC) is a public regulatory commission appointed by the Governor with the advice and consent of the Maryland Senate. A primary function of the commission is to evaluate and publish findings on the quality and performance of commercial managed care plans that operate in Maryland. MHCC produces the annual comparative reports with the cooperation of the health plans and their members. These annual performance reports are the only source of objective, comprehensive, independently audited information on health care quality. More information about MHCC and reports it produces is available at **http://mhcc.maryland.gov**.

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INTRODUCTION

INTRODUCTION

Overview

The Maryland Health Care Commission (MHCC) is committed to promoting improvements in health care by reporting on the performance of Maryland managed care organizations (MCO). For 12 years, MHCC has reported information on the quality of care and services delivered by health maintenance organizations (HMOs) and point of service (POS) health plans. This year, MHCC has taken a notable step in advancing health care quality by including performance results for preferred provider organizations (PPOs); these organizations collaborated voluntarily with the state to make health quality a priority. The *2008 Comprehensive Performance Report: Commercial HMO, POS, and PPO Plans in Maryland (Comprehensive Report)* provides plans, providers, researchers, and other interested individuals with detailed, plan-specific and Maryland-wide indicators of performance.

The *Comprehensive Report* incorporates three years of data, collected most recently in 2008, using the Health Plan Effectiveness Data and Information Set (HEDIS®[1]) measurement tool and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) 4.0H survey. The measures included in the report cover clinical quality, member satisfaction, plan descriptive features, and utilization information. The report also builds on sections that were new last year, such as the HEDIS Relative Resource Use (RRU) measures, which evaluate quality and consider the cost of delivering care.

Similar to last year, this report includes information comparing plan quality using eValue8™[3] results. eValue8 is a health plan evaluation tool that measures both quality of care and cost-effectiveness to support complex information needs of employers and their employees in making value-focused health care decisions.

Reporting multiyear performance builds a stronger depiction of how consistently a plan carries out health care delivery. Single-year results provide a snapshot and should be viewed in that context. Results tables included here illustrate changes in plans' absolute (actual) rates and relative (comparative) rates. Additionally, throughout the report stars are used to indicate plan-level performance in relation to the Maryland average.

The *Comprehensive Report* is designed to help plans, purchasers, and policymakers assess the relative quality of services delivered by managed care plans operating in Maryland. Such information has the capacity to affect purchasing and enrollment decisions, marketplace changes, and quality initiatives implemented by commercial health plans.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[3] eValue8 is a copyright of the National Business Coalition on Health.

Report Organization

The *Comprehensive Report* organizes measurement results into groups, or "domains," of related information. Maryland plans followed the guidelines in *HEDIS 2008, Volume 2: Technical Specifications* in developing their rates.

Plans are listed alphabetically in tables that display individual plan rates and the Maryland average rate.

The *Comprehensive Report* includes the following sections.

- **Summary of Performance** provides an overview of the Maryland marketplace and compendium of performance results for the plans reporting to MHCC.
- **Methodology** covers data sources, statistical methods, and general considerations for interpreting the data in this report.
- **Measure Domains** provide the following for each measure.
  - **Background** information, describes a measure's importance and any relevant clinical or population health information.
  - **Measure definition,** informs of *HEDIS 2008, Volume 2: Technical Specifications.*
  - **Data collection methodology,** indicates if Administrative, Hybrid, or Survey Methodology was used to collect the data.
  - **Summary of changes to HEDIS 2008,** lists the significant changes in measure specifications that may affect the ability to trend results.
  - **Notes,** describes any considerations regarding production or interpretation of results (where applicable).
  - **Results,** describes key rates and scores.
  - **Data tables,** consists of three-year results to show plan rates (e.g., percentages, rates per 1,000 members), significant changes in rates from 2006–2008, and relative rates (i.e., designation above, equivalent to, or below the Maryland average).
- **External Accreditation** presents the accreditation status of each plan. In Maryland, accreditation is voluntary (i.e., not required by law). Information on the various organizations that accredit managed behavioral healthcare organizations (MBHO) is included in this section, as well.
- **Appendix A: Health Plan Performance by Measure** sorts plan results by hierarchy of the scores to show which plans performed best in each measure.
- **Appendix B: Methods for Data Analyses** describes the methodology used to compare plan **performance** and rates across years for HEDIS and CAHPS 4.0H survey measures.
- **Appendix C: Methodology for Audit of HEDIS 2008 Rates from Maryland HMO, POS, and PPO Plans** summarizes the 2008 audit methodology used to verify that Maryland health plans followed the specifications of the NCQA HEDIS Compliance Audit™[4] when they calculated rates for each measure.

[4]HEDIS Compliance Audit™ is a trademark of NCQA.

- **Appendix D: Methodology for Administering CAHPS 4.0H Survey to Maryland HMO, POS, and PPO Plans** summarizes the survey methodology used to collect and calculate the CAHPS 4.0H 2008 survey results.

MHCC-specific measures are included in the *Behavioral Healthcare* section. They are part of the set of mandatory performance measures that commercial HMO and POS plans in Maryland were required to report in 2008.

Companion Maryland HMO/POS and PPO Performance Reports

Measuring the Quality of Maryland Commercial Managed Care Plans: 2008/2009 Performance Report communicates the performance of a subset of measures for each Maryland plan along with their combined average performance compared to commercial plans in the region and nation. This user-friendly report serves employers, consumers, and policymakers.

Measuring the Quality of Maryland Commercial Managed Care Plans: State Employee Guide, Spring Edition, presents the same content and format as the *2008/2009 Performance Report,* but includes only health plans available to employees of the State of Maryland.

Quality Evaluation and Reporting

Health General Article, Section 19-135 (c) charges the Maryland Health Care Commission with establishing and implementing a system for comparative evaluation of the quality of care and performance of HMOs on an objective basis. The purpose of the system is twofold.

1. Help improve quality of care by establishing a common set of performance measures.
2. Disseminate the findings to consumers, purchasers, managed care plans, and other interested parties.

A unique public-private partnership formed in 2006 between MHCC and the major health insurance carriers to broaden the positive effects of quality measurement. Aetna, CareFirst, CIGNA, Coventry, Kaiser, and United Healthcare served as early collaborators with MHCC to test the feasibility of performance measurement and reporting by PPOs. Through these significant voluntary contributions, quality evaluation and reporting has expanded to include comparisons of the breadth of managed care products—HMO, POS, and PPO—in a single, independent source. The 2008/2009 health plan performance report series represents a first-ever achievement that can serve as a model to other states.

SUMMARY OF PERFORMANCE

SUMMARY OF PERFORMANCE

This section provides an overview of trends in the health plan market and a summary of performance by the Maryland commercial plans reporting in 2008.

Health Care Trends

From Managing Illness to Promoting Health

- An aging U.S. population, increasing lifestyle risks, increasing rates of chronic illness, and rising health care costs have converged to capture employer and health plan interest in reducing health risk factors of individuals. A considerable portion of disease and related costs are caused by modifiable behaviors such as smoking and drinking habits, physical inactivity, and poor nutrition. These risk behaviors lead to chronic diseases that are having an increasing effect on both employees and employers. A study by the American Hospital Association reported that annually, 164 days of absenteeism and $30 million dollars in cost to employers is lost due to 3 chronic illnesses: asthma, diabetes, and hypertension (2007). Employers and health plans are recognizing the potential to reduce costs by preventing illness and are shifting some of the focus from disease management to encouraging health and wellness.
- Health and wellness programs offered by employers through health plans promote healthy lifestyles through assessment, education, and support. Most programs encourage healthy eating, exercise, and smoking cessation. Health risk assessment (HRA) tools are commonly used as a part of the wellness strategy. HRAs assess medical history, preventive care use, and health behaviors, and can be used to direct members towards wellness or disease management programs. Participation in these programs is voluntary; therefore, employers and health plans commonly offer employees incentives to participate, such as direct payments or a reduction in premium (Christianson, JB et al., 2008).

Health Care Premiums

- In 2007, the growth rate of health care premiums decreased to its lowest point since 1999. Although the rate of premium growth has decreased over the past five years, the average percentage increase continues to outpace inflation and wage growth. In 2007, the average premium for all plan types was $4,479 for a single person and $12,106 for a family of four. PPO plans were the most expensive with premiums averaging $4,638 for a single person and $12,443 for a family of four. Of the total premiums, employees contribute $3,236 for a family of four and $717 for single coverage, on average. HMO plans have the second most costly premiums, averaging $11,879 for family coverage and $4,299 for single coverage. POS plans are similar in pricing to HMO plans; family coverage and single coverage averages $11,588 and $4,337, respectively. For HMO plans, the out-of-pocket employee contribution is slightly less than a POS plan for a family of four and slightly more for single coverage. The employee contribution for family coverage averages $3,311 for HMO plans and $3,659 for POS plans. For single coverage, employee contribution averages $711 for HMO plans and $628 for POS plans (Kaiser, 2008).

Maryland Health Plans in this Report

This report includes HMO, POS, and PPO plans that primarily serve the commercially insured population and receive over 1 million dollars in Maryland premiums. Each plan has the option of reporting combined performance results for its HMO and POS products, but only if the POS plan operates under the license of its HMO. Each plan (with the exception of Kaiser Permanente) has chosen that option. References to HMOs and HMO members throughout this report should be understood to include POS members for six of the seven plans. The number of plans reporting to MHCC remained the same for 2007 and 2008.

This year comparative data collected voluntarily by health insurance carriers on their PPO products has become available and included in the state's health plan performance reports for the first time. According to the American Association of Preferred Provider Organization, 66 percent of Americans who had health insurance were enrolled in PPOs in 2007.

Table 1 shows the names of the HMO/POS plans and PPO plans offered by the principal carriers in Maryland whose data are presented in this report.

Table 1: Health Plans reporting in 2008

HMO/POS Plans	**PPO Plans**
Aetna Health, Inc.—Maryland, DC and Virginia (Aetna)	Aetna Life Insurance Company (Aetna PPO)
CareFirst BlueChoice, Inc. (BlueChoice)	CareFirst BluePreferred PPO (BluePreferred)
CIGNA HealthCare Mid-Atlantic, Inc. (CIGNA)	Connecticut General Life Insurance Company (CGLIC)
Coventry Health Care of Delaware, Inc. (Coventry)	
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente)	
MD Individual Practice Association, Inc. (M.D. IPA)	MAMSI Life and Health Insurance Company (MAMSI Life)
Optimum Choice, Inc. (OCI)	

Table 2 shows the percentage of members enrolled in the plans' HMO and POS plans. PPOs did not report enrollment numbers.

Table 2: Maryland HMO/POS Enrollment, 2007

Health Plan	Number of Plan Members	% of Members Enrolled in HMO	% of Members Enrolled in POS
Aetna	300,543	31%	9%
BlueChoice	619,482	65%	35%
CIGNA	227,346	57%	43%
Coventry	112,778	86%	14%
Kaiser Permanente	454,507	95%	5%
M.D. IPA	205,793	86%	14%
OCI	342,292	84%	16%

Below is a brief overview of the plans' operating structures.

- **Aetna** and **CIGNA**, for-profit HMOs and PPOs, **Coventry**, a for-profit HMO, and **Kaiser Permanente**, the only non-profit HMO operating in Maryland, represent national health care insurers in Maryland.
- **BlueChoice** and **BluePreferred** are for-profit and operate under a holding company called CareFirst. CareFirst, Inc. is the not-for-profit parent company of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., affiliates that do business as CareFirst BlueCross BlueShield.
- **M.D. IPA** and **OCI**, for-profit HMOs, and **MAMSI Life**, a for-profit PPO, are owned and operated by Mid Atlantic Medical Services, LLC (MAMSI), a regional holding company and subsidiary of UnitedHealth Group, Inc.

One-Year Above-Average Performance

Table 3 displays the number of instances, by domain, where each HMO/POS plan had above-average scores. Based on the total measures reported in 2008, HMO/POS plans had the potential to achieve above-average rankings on 46 HEDIS and 9 CAHPS measures.

Results of clinical measurement (HEDIS) show that Kaiser Permanente received the most above-average scores by achieving this ranking for 20 measures (43 percent). CIGNA followed with above-average scores in 17 measures (37 percent). These top-ranking plans performed equally in the *Effectiveness of Care* domain, as both matched in the highest number of above-average scores. BlueChoice ranked third overall, with above-average scores in 12 measures (26 percent). M.D. IPA and Aetna received five above-average scores, while OCI received one above-average score.

Summary results of the nine CAHPS measures show Coventry and CIGNA performed best compared to the other plans, with above-average scores in two measures. Notably, Coventry did not receive any above-average scores on HEDIS measures. Finally, M.D. IPA received one

above-average score and the remaining four plans received no above-average scores in the area of member satisfaction.

Table 4 displays the above- average scores for PPO plans. PPOs reported plan specific results for a total of 11 HEDIS measures. MAMSI Life and Aetna PPO achieved above-average scores in three measures; CGLIC and BluePreferred each received one above-average score.

PPO plans reported on all nine CAHPS measures. Of the measures, BluePreferred and MAMSI Life received four above-average scores, while the other plans did not receive any.

In determining the above-average count, composite rankings have been used to summarize plans' performance; therefore, the number of eligible measures is sometimes less than the number of total measures in each domain. Results for individual components in a composite are excluded from a plan's total count. For example, the *Childhood Immunization Status (Combination 2)* measure counts as one measure; results for each antigen are not counted individually.

See *Appendix A: Health Plan Performance by Measure* for detailed rankings and results of all measures.

Table 3: HMO/POS Above-Average Scores, 2008

	Effective-ness of Care	Access/ Availability of Care	Beha-vioral Health	Health Plan Descriptive Information	Total HEDIS	Total CAHPS	Total HEDIS/ CAHPS
Total Number of Measures in Each Domain	**29**	**4**	**8**	**4**	**46**	**9**	**55**
Aetna	2	1	1	0	5	0	5
BlueChoice	6	1	6	0	12	0	12
CIGNA	13	3	0	2	17	2	19
Coventry	0	0	0	1	0	2	2
Kaiser Permanente	13	0	5	4	20	0	20
M.D. IPA	3	1	1	0	5	1	6
OCI	0	0	1	0	1	0	1

Table 4: PPO Above-Average Scores, 2008

	Effective-ness of Care	Access/ Availability of Care	Beha-vioral Health	Health Plan Descriptive Information	Total HEDIS	Total CAHPS	Total HEDIS/ CAHPS
Total Number of Measures in Each Domain	**6**	**NA**	**5**	**NA**	**11**	**9**	**20**
Aetna PPO	3		0		3	0	3
BluePreferred	1		0		1	4	5
CGLIC	0		1		1	0	1
MAMSI Life	2		1		3	4	7

NA-Not applicable; PPO measurement set did not include measures in this domain.

METHODOLOGY

METHODOLOGY

This section describes the data and statistical methods used to determine relative plan performance and the statistical significance of trends. This report presents results, primarily collected using HEDIS and CAHPS, from seven HMO/POS and four PPO Maryland plans in seven areas of assessment.

1. Effectiveness of Care
2. Access/Availability of Care
3. Satisfaction with the Experience of Care
4. Behavioral Healthcare
5. Use of Services
6. Cost and Efficiency
7. Health Plan Descriptive Information

Data Sources

Data reported in the *Comprehensive Report* are drawn primarily from two sources: HEDIS performance measures and the CAHPS 4.0H survey. In addition, to satisfy legislative, task force, and MHCC requirements, plans report on several measures of performance specific to Maryland, referred to as "MHCC-specific" measures.

HEDIS Measures

HEDIS is a standard set of performance measures developed by the National Committee for Quality Assurance (NCQA), with assistance from experts representing many fields. NCQA is a not-for-profit organization that assesses, accredits, and reports on the quality of MCOs, including HMOs, POS plans, and PPOs.

Rates reported for HEDIS 2008 measurement set reflect services delivered during the 2007 calendar year (CY). Similarly, 2007 and 2006 results presented in this report for trending purposes reflect performance experiences from CY 2006 and CY 2005, respectively. Based on the state's reporting requirements, the Maryland Health Care Commission required that plans report 46 HEDIS measures for reporting year 2008. Several measures required collecting multiple rates. For example, the *Childhood Immunization Status* measure has two numerators to assess the percentage of children receiving the recommended combination of immunizations with and without pneumococcal conjugate, thereby resulting in two separate rates for one measure. In addition, Maryland plans were asked to provide specific data and information about their behavioral health networks.

HEDIS measurement processes and results collected by plans for MHCC have been audited by certified auditors according to the NCQA HEDIS Compliance Audit protocol. The audit program, established by NCQA, is a standardized methodology that enables organizations to compare plan results for HEDIS performance measures directly. The audit is a two-part process that consists of an assessment of overall information systems capabilities, followed by an evaluation of the plan's ability to comply with HEDIS specifications. HealthcareData Company, LLC,

performed the HEDIS audit functions on site at participating plans that submitted the data displayed throughout this report, under a separate, competitively-bid contract with the MHCC. See Appendix C for more information regarding the audit process.

Data Collection Methodology

To capture representative results effectively, HEDIS gives HMO/POS plans the choice to use either the Administrative Method or the Hybrid Method of data collection. The Hybrid Method allows health plans to supplement rates typically calculated from administrative data systems that gather information from member medical records. By using the Hybrid Method, health plans can produce rates that reflect actual performance better. The majority of the 11 measures eligible for the Hybrid Method are in the Effectiveness of Care domain, with the exception of the *Prenatal and Postpartum Care* and *Well-Child Visit* measures, which are in the *Access/Availability of Care* and *Use of Services* domains, respectively.

For HEDIS 2008, only HMO and POS plans have the option to report eligible measures using the Hybrid Method. NCQA's protocol requires that PPOs report all HEDIS measures using the Administrative Method, since their presence in multistate service areas presents a barrier to accessing medical records. MHCC will confer with the participating health plans and certified audit firm about annual assessment of the feasibility of using the Hybrid Method to collect data on eligible measures.

Briefly, the basic steps of the two methods are as follows:

- ***Administrative Method:*** After identifying the eligible member population for a measure, health plans search their administrative database (claims and encounter systems) for evidence of the service. For some measures, rates calculated using the Administrative Method might be slightly lower than rates calculated for the same measure using the Hybrid Method.
- ***Hybrid Method:*** After selecting a random sample of eligible members for a measure, the health plan searches its administrative databases for information about whether each individual in the sample received the service. If the administrative database does not contain the information, the plan will then consult medical records to confirm that individuals in the sample received the service.

Plans that use only administrative data to generate rates eligible for hybrid collection are indicated by a superscript "m" (^{m}) in the results tables.

Rotation of Measures

NCQA allows health plans to *rotate* data collection for selected HEDIS measures. For the set of eligible measures, data may be collected once and reported for two consecutive years. The measures that NCQA selects for rotation are those that potentially impose a substantial burden for health plans to collect, have been part of the HEDIS measurement set for at least two years, and for which no significant changes have been made to the methods used to collect and report data. Since this is the first year Maryland is publicly reporting on PPO performance, PPOs reported results for a limited measurement set that included only measures collected using the Administrative Method; therefore, measure rotation does not apply to rates submitted in 2008.

If a health plan rotates a measure for its HMO/POS plan, valid results reported to MHCC in 2007 are also shown as 2008 results in this report. Table 5 indicates the measures that each plan rotated and the collection method used for hybrid eligible measures.

Plans that rotate the measure are identified by a superscript "r" (^{r}) in the results tables.

Table 5: Plan Use of Hybrid Method and Rotated Measure Results

A = Administrative H = Hybrid R = Rotated	Aetna	Blue Choice	CIGNA	Coven-try	Kaiser	M.D. IPA	OCI
Childhood Immunization Status	H	H	H	H	H	H	H
Colorectal Cancer Screening	A	H	H	A	A	H	H
Cervical Cancer Screening	A	H	R	R	R	H	A
Controlling High Blood Pressure	H	R	R	R	R	H	H
Cholesterol Management for Patients With Acute Cardiovascular Conditions	H	A	H	H	H	H	H
Comprehensive Diabetes Care	H	H	H	H	H/A*	H	H
Prenatal and Postpartum Care	R	R	R	R	R	R	H
Well-Child Visits in the First 15 Months of Life	A	A	A	A	A	H	H
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	A	A	A	A	A	H	H
Adolescent Well Child Visits	A	A	A	A	A	H	H

*The Administrative Method was used for eye exam measure only

<u>*Not Report* and *Not Applicable* Designations</u>

Plans must report a rate for each measure included in the MHCC performance reporting set; they do not have the option of choosing not to calculate or not report rates for these measures. Therefore, each *Not Report (NR)*[5] designation that appears in the Maryland health plan performance reports means that the plan did not pass the audit for that measure.

When a plan can accurately generate a rate but the denominator (i.e., the number of members who meet criteria for a measure) is less than 30, its rate is reported as *Not Applicable (NA)*. NCQA's guidelines set 30 as the lower acceptable limit for denominators. If fewer than 30 people constitute the population undergoing comparison, the statistical validity and measure meaningfulness is compromised.

[5] According to NCQA guidelines, measures are assigned *NR* if they meet the following criteria: 1.) The plan chose not to report the rate; or 2.) The plan calculated the measure but the rate was materially biased. For measures reported as a rate (e.g., *Effectiveness of Care*) and for the three service measures, "materially biased" is an error that causes a ±5 percentage point difference in the reported rate. For nonrate measures (e.g., *Use of Services* and survey measures), materially biased is an error that causes a ±10 percent change in the reported rate.

CAHPS 4.0H Survey Measures

The *Satisfaction with the Experience of Care* section of this report contains survey results from health plan members. The CAHPS survey (included in the HEDIS measurement set) has been administered to randomly selected samples of Maryland health plan members enrolled in commercial products.

Various versions of the CAHPS survey have been created—adult, child, and product-specific surveys for commercial, Medicaid, and Medicare health plan members. All versions of the survey contain question sets covering such topics as enrollment and coverage, access to and utilization of health care, communication and interaction with providers, interaction with health plan administration, self-perceived health status, and respondent demographics.

MHCC contracted with WB&A Market Research to administer the CAHPS 4.0H survey to the adult, commercial HMO/POS, and PPO populations. A random sample of 1,210 members from each health plan was surveyed in 2008. The survey was administered according to the protocol outlined by NCQA in *HEDIS 2008, Volume 3: Specifications for Survey Measures*. See Appendix D for additional information regarding survey methodology.

Statistical Analysis

Calculation of Relative Rates

All plans contribute equally to the average rate of performance (i.e., the average rate for HMO/POS plans is determined by adding the rate for each HMO/POS plan and dividing by seven); individual plan rates are then compared to the un-weighted average rate of performance for all seven HMO/POS Maryland plans. This same method was applied to derive relative performance of the four Maryland PPO plans. If the difference between a plan's rate and the Maryland HMO/POS or PPO average is statistically significant, the plan is assigned to the "above average" or "below average" category, accordingly. To determine the statistical significance of differences between the two values, a modified t-test is conducted to account for potential random errors in measurement of the individual plan's rate, as well as potential random errors in measurement of the Maryland HMO/POS or PPO average. A 95 percent degree of confidence is used to determine whether the difference between the rates is statistically significant. See Appendix B for a detailed description of this methodology.

The tables in this report use the following symbols to denote relative comparisons.

★★★ = Individual plan rate significantly better than the Maryland average.
★★ = Individual plan rate equivalent to the Maryland average.
★ = Individual plan rate significantly worse than the Maryland average.

In some situations, two plans with the same rate are classified into two different performance rating categories. This is a result of the data collection methodology used by the plans. Plans that use the Administrative Method tend to have smaller confidence intervals because the entire eligible population for the measure is used as the measure denominator, rather than a sample of the population. This results in a larger denominator, which allows for a more precise estimation of the true rate. In statistical terms, the confidence interval around the rate is smaller. *This means that statistical examination of two plans with the same percentage rate can result in two different performance strata.* For example, Plan A and Plan B both report a rate of 85 percent for a given measure. The Maryland HMO/POS average for this example is 80 percent. Plan A used the

Hybrid Method and its performance is designated as "average" because of its larger confidence interval, when compared with the state average for all seven plans. Plan B used the Administrative Method and its performance is designated as "above average," since its narrower confidence interval excludes the Maryland HMO/POS average. Additionally, plans with the same rate could be designated as performing at two different levels because **statistical tests were conducted using entire numbers without rounding**. Rates were rounded for display in this report.

Understanding Data Comparisons and Changes From 2006–2008

Comparison over time provides an assessment of the quality of services offered by plans and an opportunity to look at trends toward improved performance. The tables contain a column titled "Change 2006–2008," which indicates whether a change in a plan's actual rate from 2006–2008 is statistically significant and, if so, the direction of the change. It is an indicator of the consistency of a plan's performance over time rather than its performance in relation to other plans.

The tables use the following symbols.

- ↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
- ⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
- ↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Because this indicator shows whether a plan's actual rate improved over time, it is independent of the plan's relative rating. To illustrate how this indicator differs from the relative rating indicator, a plan's rate may have changed from 65 percent in 2006 to 75 percent in 2008—a significant increase that would be identified with the "↑" symbol; however, if the Maryland HMO/POS average changed from 60 percent in 2006 to 80 percent in 2008 it is possible for the relative ranking to remain unchanged, or even decline. For example, the plan's relative rating may have been above average in 2006 but below average in 2008 because of the upward shift in the Maryland HMO/POS average. Over time, the plan shows a statistically significant increase in its performance, but it increased less significantly than the Maryland HMO/POS average over the same period.

The three columns titled "Comparison of Relative Rates" show how each plan performed in relation to the other plans that reported each year. The relative score is an indicator of the plan's performance (above, average, or below average) relative to the Maryland HMO/POS or PPO average.

Percentiles

NCQA annually releases Quality Compass®[6], which contains HEDIS rates and averages obtained from hundreds of HMOs across the country. These data are used to construct scores by quartile and for the top (90th percentile) and bottom (10th percentile) deciles. A score in the top decile is higher than the scores of at least 90 percent of the HMOs that report to Quality Compass; a score in the bottom decile is a score that is lower than the scores of at least 90 percent of the HMO scores in Quality Compass.

[6] Quality Compass® is a registered trademark of NCQA.

Rates and averages that are in the top and bottom deciles in the *Use of Services* section of this report are indicated by the following symbols.

▲ = The plan rate is higher than 90 percent of other plans nationally

▼ = The plan rate is lower than 90 percent of other plans nationally

General Considerations for Interpreting Information

PPOs Voluntarily Reporting for the First Time

Participating PPOs voluntarily submitted data for public reporting on 11 HEDIS measures and all CAHPS measures. Because this is the first year that PPOs have voluntarily submitted and reported performance information to Maryland, trend data are not available. PPOs were required to collect data using the Administrative Methodology only. By restricting data collection to one methodology, it possibly limited the opportunity to report more precise rates through medical record abstraction, which the Hybrid Method allows.

Data Completeness

A plan may not have complete data on all of the services rendered to its members for reasons described below.

- In plan mergers or acquisitions, the surviving health plan must integrate all data from predecessor plans for future HEDIS reporting. Administrative data system conversions can be complex and can lead to data loss. Even if a system conversion has not taken place, creating HEDIS measures from multiple systems can raise data integration issues that may lead to data loss.
- For some HMO providers, payment is capitated and is not associated with each service rendered to enrollees; therefore, providers may not always submit the encounter information to the HMO, even though care was provided.
- Many HMOs do not receive complete patient data from contractual vendors that provide laboratory, radiology, pharmacy, and mental health services. Plans have improved data transfers from vendors, however, by implementing incentive programs and setting this requirement as part of their contracts.

These factors, along with the choice of the Administrative Method vs. the Hybrid Method of data collection, can cause either underreporting or over reporting of HEDIS results that is not attributable to differences in performance. Although plans continually work to improve their data for use in performance measurement and quality improvement, demonstrating the effects of these factors on final HEDIS rates is extremely difficult.

Performance Measurement Issues

Health plan performance assessment methods are continually under development. Each year, HEDIS measures are refined and new measures are added to create a reliable and valid means of evaluation. Factors to consider when interpreting the results are highlighted throughout this report, when applicable. In addition to differences in quality, the following issues can cause variation in HEDIS results.

- HEDIS measures collected using the Hybrid or Administrative Method are calculated from samples of a plan's eligible population. Although plans' sampling methods conform to statistical methods, there is still a small chance that the sample does not represent the underlying population. The likelihood of this random error occurring is small, but the estimate obtained with a sample may produce a result that exceeds the error tolerance of 5 percent set by HEDIS specifications.
- Some measures in the *Effectiveness of Care* domain allow optional exclusions. This means that health plans are allowed to exclude certain members from the denominator if they are identified as having had a certain procedure or comorbidity (e.g., women who have had bilateral mastectomies may be excluded from the *Breast Cancer Screening* measure). The health plan is not required to make these exclusions, but may do so to improve the accuracy of its rates.
- HEDIS results are not risk adjusted, which may account for variation in rates for some measures, such as those in the Use of Services domain and the *Frequency of Selected Procedures* measure. There may be differences in plan populations that cause rate variation, even when the quality of health care delivered is the same. For example, Plan A may have a sicker population than Plan B. Although both plans may provide the same quality of care, Plan A may have higher utilization rates for some services because its members need more medical care than the healthier members of Plan B do. Consequently, results are not due to differences in performance.

EFFECTIVENESS OF CARE

EFFECTIVENESS OF CARE

Overview

This section contains results for measures in the HEDIS 2008 Effectiveness of Care domain that MHCC required Maryland commercial HMO/POS plans to report in 2008. PPOs voluntarily reported results for six HEDIS and two CAHPS measures included in this domain.

Effectiveness of Care measures indicate the percentage of people who received a recommended and needed service. The measures are designed to illustrate a plan's delivery of clinical services in accordance with established and widely accepted guidelines. For all of the measures presented in this section, higher rates indicate better performance.

Measures in Domain

- Annual Monitoring for Patients on Persistent Medications
- Appropriate Testing for Children With Pharyngitis†
- Appropriate Treatment for Children With Upper Respiratory Infection (URI) †
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis†
- Breast Cancer Screening†
- Cervical Cancer Screening
- Childhood Immunization Status
- Chlamydia Screening in Women
- Cholesterol Management for Patients With Cardiovascular Conditions
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Flu Shots for Adults Ages 50–64†
- Medical Assistance With Smoking Cessation†
- Persistence of Beta-Blocker Treatment After a Heart Attack†
- Pharmacotherapy Management of COPD Exacerbation
- Use of Appropriate Medications for People With Asthma†
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD

†*Comparative data provided for HMO/POS and PPO health plans*

Measures eligible for rotation in HEDIS 2008

- Cervical Cancer Screening
- Controlling High Blood Pressure

Plans that rotated a measure are identified by a superscript "r" (^{r}) in the results tables.

CHILDHOOD IMMUNIZATION STATUS

Background

Vaccines are one of the most effective public health mechanisms to prevent disease. Since their introduction in the twentieth century, childhood vaccinations have decreased the incidence and prevalence of various infectious diseases once common in the United States, including but not limited to polio, measles, diphtheria, whooping cough, rubella (German measles), mumps, and tetanus (CDC 2006).

The Centers for Disease Control and Prevention (CDC) annually updates the series of vaccines recommended for U.S. children 19–35 months of age. The recommended vaccination series (4:3:1:3:3:1) for 2008 includes four doses of diphtheria, tetanus, and pertussis vaccine; three doses of polio vaccine; one or more doses of measles, mumps, and rubella vaccine; three doses of *Haemophilus influenzae* type b vaccine ; three doses of hepatitis B vaccine; and one or more doses of varicella (chickenpox vaccine). The pneumococcal vaccine and rotavirus vaccine are not a part of the 4:3:1:3:3:1 series, but are recommended for healthy children by the CDC.

Table 6: CDC Recommended Childhood Immunizations

Age	DTaP/ DT	IPV	MMR	Hep B	HiB	VZV	PCV	Rota
Birth–2 months				✓				
1–4 months				✓				
2 months	✓	✓			✓		✓	✓
4 months	✓	✓			✓		✓	✓
6 months	✓				✓		✓	✓
6–18 months		✓		✓				
12–15 months			✓		✓	✓	✓	
12–18 months								
15–18 months	✓							

Source: American Academy of Family Physicians, Recommended Immunization Schedule for Ages 0-6 Years–United States, 2008

Vaccine Abbreviations

DTaP/DT = Diphtheria, tetanus, and pertussis vaccine/diphtheria, tetanus
IPV = Inactivated polio vaccine (polio)
MMR = Measles, mumps, and rubella
Hep B = Hepatitis B
HiB = Haemophilus influenza type b
VZV = Varicella zoster virus (chicken pox)
PCV = Pneumococcal conjugate vaccine (pneumonia)
Rota = Rotavirus

Note: *The rotavirus vaccine is recommended by the CDC, but is not included in HEDIS 2008*

Data from the National Immunization Survey (July 2006–June 2007) show that in Maryland 84.9 percent of children 19-35 months of age received the recommended 4:3:1:3:3:1 series compared with the national percentage of 77.5. A higher percentage of Maryland children also received each of the seven vaccines, compared with national levels.

Table 7: Estimated Percentage of Vaccination Coverage for the United States and Maryland for Seven Individual Vaccines 19–35 Months of Age

	DTaP/DT	IPV	MMR	Hep B	Hib	VZV	PCV (3 or more doses)
Maryland	88.6	94.5	95.5	95.9	97.1	94.7	91.3
Nation	85.1	92.7	92.4	92.9	93.0	90.0	88.9

Estimates are based on 95 percent confidence interval

Source: National Immunization Survey, Centers for Disease Control and Prevention

ImmuNet, Maryland's immunization registry, is a confidential and secure computer database designed to collect and maintain accurate, confidential, and current vaccination records. The Maryland Center for Immunization offers ImmuNet to Maryland immunization providers. ImmuNet currently contains over 1 million patient records. Used in 217 provider offices statewide, it helps providers and health plans track when children need vaccinations. Some of its features include assisting in vaccine management, printing completed school immunization certificates, consolidating immunization records, and providing offices with the capability to print reminders. Immunet helps public health officials improve the overall status of immunization in Maryland.

Measure Definition

The *Childhood Immunization Status* measure shows the percentage of two-year-old children who were continuously enrolled in their health plan for the 12 months immediately preceding their second birthday, and received the vaccines listed below. The measure produces rates for each combination of antigens and rates for the specific antigens composing each combination series.

Combination 2	Combination 3
4 DTaP/DT	4 DTaP/DT
3 IPV	3 IPV
1 MMR	1 MMR
3 Hep B	3 Hep B
3 HiB	3 HiB
1 VZV	1 VZV
	4 PCV

Data Collection Methodology

This measure is collected using the Hybrid Method.

Summary of Changes to HEDIS 2008

Coding and numerator evidence changes made to this measure do not affect comparability to prior years' results included in this report. Refer to *HEDIS 2008, Volume 2: Technical Specifications*, the specific details pertaining to code and measure compliance changes.

Notes

Several factors complicate calculating this measure and can lead to underreporting. When interpreting results, readers should consider the following.

- Children who receive some—or even most—but not all of the immunizations specified for the combination are considered noncompliant with measure specifications and are not counted in the numerator for *Combination 2* and *Combination 3*. Vaccine-specific or single antigen rates are almost always higher than combination rates.
- Plans may have difficulty documenting immunizations that children received outside their provider network (e.g., local health departments).
- Disease history may not be documented. Unless a child's medical record shows evidence of having had a disease, underreporting will occur without the necessary documentation of the specific medical event.
- Poor quality of coding for ambulatory data is commonly found in capitated managed care environments and can complicate accurate measurement. This happens when providers do not include antigen-specific codes for immunizations on encounter forms submitted to plans.
- Many children receive recommended immunizations shortly *after* their second birthday. Although the intent of the measure is satisfied, these children must be excluded (as indicated in *HEDIS 2008, Volume 2: Technical Specifications*, which guides the calculation of rates for HEDIS measures to ensure comparability of results across plans).

HMO/POS Results

Combination 2 (see Table 8)

- From 2006–2008, the Maryland HMO/POS average increased by 3 percentage points to 83 percent. One plan significantly increased its rate during this period.
- In 2008, rates ranged from 81–87 percent, with one plan receiving an above-average score and the remainder of the plans receiving average scores.

Table 8: Childhood Immunization Status Combination 2, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**81%**	**81%**	**83%**	**3%**			
Aetna	84%	84%	85%	⇔	★★★	★★	★★
BlueChoice	83%	80%	82%	⇔	★★	★★	★★
CIGNA	85%	85%	87%	⇔	★★★	★★★	★★★
Coventry	77%	77%	81%	⇔	★	★	★★
Kaiser Permanente	86%	86%	86%	⇔	★★★	★★★	★★
M.D. IPA	73%	79%	82%	↑	★	★★	★★
OCI	76%	75%	81%	⇔	★	★	★★

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Combination 3 (see Table 9)

- In 2008, rates ranged from 73–82 percent, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.

Table 9: Childhood Immunization Status Combination 3, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland HMO/POS Average	**77%**	
Aetna	77%	★★
BlueChoice	73%	★
CIGNA	82%	★★★
Coventry	76%	★★
Kaiser Permanente	81%	★★
M.D. IPA	76%	★★
OCI	76%	★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Antigen- Specific Vaccination Results (see Table10)

- The Maryland HMO/POS averages for antigen specific vaccinations ranged from 84-95 percent, with the highest rate observed for the MMR vaccine and the lowest rate observed for the PCV vaccine.

Table 10: Childhood Immunization Status, 2008 Results- Percentage of Children Immunized

	Combo 2		Combo 3		DTaP		IPV		MMR		HiB		Hep B		VZV		PCV	
Maryland HMO/POS Average	**83%**		**77%**		**89%**		**93%**		**95%**		**94%**		**92%**		**94%**		**84%**	
Aetna	85%	★★	77%	★★	91%	★★	94%	★★	96%	★★	98%	★★★	93%	★★	95%	★★	83%	★★
BlueChoice	82%	★★	73%	★	87%	★★	92%	★★	94%	★★	93%	★★	90%	★★	93%	★★	79%	★
CIGNA	87%	★★★	82%	★★★	90%	★★	93%	★★	96%	★★	95%	★★	94%	★★	96%	★★★	87%	★★★
Coventry	81%	★★	76%	★★	87%	★★	91%	★★	97%	★★★	93%	★★	91%	★★	96%	★★	84%	★★
Kaiser Permanente	86%	★★	81%	★★	89%	★★	94%	★★	95%	★★	90%	★	95%	★★★	95%	★★	86%	★★
M.D. IPA	82%	★★	76%	★★	88%	★★	94%	★★	94%	★★	96%	★★	91%	★★	93%	★★	84%	★★
OCI	81%	★★	76%	★★	89%	★★	92%	★★	93%	★★	93%	★★	88%	★	92%	★★	83%	★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Background

Pharyngitis, the inflammation of the pharynx, originates from a virus or bacteria. Only 15–30 percent of pharyngitis cases stem from Group A Streptococcal bacteria, with the remainder arising from viruses or non-streptococcal bacteria (Bisno, 2001). Although the majority of pharyngitis cases are not caused by bacteria, physicians continue to treat the illness with antibiotics. Superfluous prescribing of antibiotics can lead to the development of bacterial resistance.

The American Academy of Pediatrics (AAP), the CDC and the Infectious Diseases Society of America (IDSA) advise physicians to administer a strep test to validate a bacterial cause of pharyngitis before prescribing antibiotics (Linder, et al., 2005). Despite this recommended guideline, many physicians treat pharyngitis with antibiotics before they have strep test results. In fact, 42 percent of physicians surveyed across the nation indicated that they would start antibiotic treatment before knowing the results of a strep test. These same physicians indicated that they would continue treatment even after receiving a negative strep test (Park SY, et al., 2006).

Antibiotic prescription behavior among physicians may be in part due to patients' expectations for treatment and perceptions that more care is better. Researchers found a small difference in patient satisfaction when prescribed antibiotics: 86 percent of patients were very satisfied or extremely satisfied if they received an immediate antibiotic versus 77 percent who received a delayed antibiotic and 72 percent who received no antibiotic (Little, et al., 2005). Educational campaigns targeted towards stakeholder groups, such as physicians and parents, are important in effective and efficient antibiotic use.

Measure Definition

The *Appropriate Testing for Children With Pharyngitis* measure shows the percentage of children 2–18 years of age who were diagnosed with bacterial pharyngitis, dispensed an antibiotic, and received a Group A streptococcus test for the episode. A higher rate represents better performance with regard to appropriate testing.

Data Collection Methodology

This measure is collected using the Administrative Method.

Summary of Changes to HEDIS 2008

Episode definitions have been standardized. Coding and numerator evidence changes made to this measure do not affect comparability to prior years' results included in this report.

HMO/POS Results *(see Table 11)*

- Between 2006 and 2008, six of the seven HMO/POS plans significantly increased their rates and one plan's rate significantly decreased. The overall Maryland HMO/POS average increased by 8 percentage points over this time period.
- Two HMO/POS plans performed significantly above the Maryland HMO/ POS average and four plans performed significantly below the average.

Table 11: Appropriate Testing for Children With Pharyngitis, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**74%**	**78%**	**82%**	**8%**			
Aetna	71%	76%	81%	↑	★	★	★★
BlueChoice	76%	73%	80%	↑	★★★	★	★
CIGNA	76%	78%	83%	↑	★★★	★★	★★★
Coventry	65%	72%	76%	↑	★	★	★
Kaiser Permanente	94%	93%	92%	↓	★★★	★★★	★★★
M.D. IPA	68%	77%	80%	↑	★	★★	★
OCI	67%	75%	80%	↑	★	★	★

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

PPO Results *(see Table 12)*

- The rates for PPO plans ranged from 81–84 percent in 2008. All plans' performance was equivalent to the Maryland PPO average.

Table 12: Appropriate Testing for Children With Pharyngitis, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**83%**	
Aetna PPO	82%	★★
BluePreferred	81%	★★
CGLIC	83%	★★
MAMSI Life	84%	★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.

APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

Background

Upper respiratory infection (URI), also known as the common cold, leads to more doctor appointments and school absences than any other illness each year. On average, children get six to eight colds a year, compared to adults who average two to four (Children's Hospital Boston, 2007).

URIs stem from various types of viruses, the most common being the rhinovirus. As is the case with pharyngitis, pediatric antibiotic overuse for URI has become a problem in the United States. Treating viral infections with antibiotics is ineffective and continuous use can lead to the development of bacteria strains that resist treatment (U.S. Food and Drug Administration, n.d.).

Following a public health campaign on inappropriate antibiotic use, researchers surveyed parents' health beliefs and knowledge of URIs and antibiotic use. The study found lower expectations of antibiotic treatment among parents cognizant of antibiotics' inability to remedy such an infection (Vinker, Ron, and Kitai, 2003)

As with the *Appropriate Treatment for Children With Pharyngitis* measure, this health concern should be addressed on a broad level. Improving awareness of health professionals, parents and the general public, as well as reinforcing the guidelines for treating URI, can help decrease the inappropriate use of antibiotics.

Measure Definition

The *Appropriate Treatment for Children With Upper Respiratory Infection* measure shows the percentage of children 3 months to 18 years of age who were diagnosed with URI and *were not* dispensed an antibiotic on or three days after the diagnosis. This measure assesses whether antibiotics were inappropriately prescribed for children with a URI.

This measure is reported as an inverted rate [1 – (numerator/denominator)]; therefore, a higher score indicates appropriate treatment of children with a URI (the number of children who *were not* prescribed an antibiotic).

Data Collection Methodology

This measure is collected using the Administrative Method.

Summary of Changes to HEDIS 2008

Episode definitions have been standardized. Coding and medication changes made to this measure do not affect comparability to prior years' results included in this report.

HMO/POS Results *(see Table 13)*

- The Maryland HMO/POS average decreased four percentage points between 2006 and 2008. The rates for three plans significantly decreased over this period and two plans significantly increased their rates.
- The rates in 2008 for HMO/POS plans ranged from 78–93 percent; the Maryland average was 85 percent. Four plans performed significantly above the Maryland average and three plans performed significantly below the average.

Table 13: Appropriate Testing for Children With Upper Respiratory Infection, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**89%**	**84%**	**85%**	**-4%**			
Aetna	84%	84%	87%	↑	★	★★	★★★
BlueChoice	94%	81%	81%	↓	★★★	★	★
CIGNA	85%	84%	86%	⇔	★	★★	★★★
Coventry	77%	81%	78%	⇔	★	★	★
Kaiser Permanente	91%	94%	93%	↑	★★★	★★★	★★★
M.D. IPA	95%	85%	84%	↓	★★★	★★	★★
OCI	94%	82%	83%	↓	★★★	★	★

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

PPO Results *(see Table 14)*

- The Maryland PPO average in 2008 was 85 percent. Plan rates ranged from 83-89 percent, with only one plan receiving a score significantly above the Maryland average.

Table 14: Appropriate Testing for Children With Upper Respiratory Infection, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**85%**	
Aetna PPO	89%	★★★
BluePreferred	83%	★
CGLIC	86%	★★
MAMSI Life	83%	★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.

AVOIDANCE OF ANTIBIOTIC TREATMENT IN ADULTS WITH ACUTE BRONCHITIS

Background

Acute bronchitis stems from viruses, sometimes the same virus that causes the common cold (Mayo Clinic, 2008). Each year it affects an estimated 44 out of 1,000 Americans, 16 years of age and older (Wark, 2004).

A study concluded that there is no evidence in current literature to support prescribing antibiotics to treat short-term bronchitis because the disease is almost always caused by viruses, which do not respond to antibiotics (Braman, 2006). Despite these findings, Wenzel & Fowler (2006) found 70–80 percent of people who develop bronchitis are prescribed antibiotics for treatment lasting 5–10 days. Overuse of antibiotics leads to more drug-resistant organisms and may render disorders more difficult to treat in the future. In light of this, the CDC recommends against antibiotic use in acute bronchitis (Ong, 2007).

Some physicians have argued that prescribing antibiotics for acute bronchitis is more efficient and maintains patient satisfaction (Little, et. al, 2005). Research has not found a direct association between antibiotic prescribing and patient satisfaction (Linder and Singer, 2003); patients tend to be satisfied when they perceive their physician has expressed interest in them, provided reassurance, and explained their illness and treatment options. Although patient satisfaction is important, it should not be the measure used for the quality of care; physicians should focus on patient outcome.

Measure Definition

The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure shows the percentage of adults 18–64 with a diagnosis of acute bronchitis and were not dispensed an antibiotic prescription.

This measure is reported as an inverted rate (1-[numerator/eligible population]). A higher rate indicates appropriate treatment of adults with acute bronchitis (the proportion of adults for whom antibiotics were not prescribed).

Data Collection Methodology

This measure is collected using the Administrative Method.

Summary of Changes to HEDIS 2008

This measure was renamed from *Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis*, and was inverted. Changes that were made to coding and data elements inhibit comparability to prior years' results.

Notes

- Antibiotics are not indicated in clinical guidelines for treating adults with acute bronchitis who do not have a comorbid illness or other infection for which antibiotics may be appropriate.

HMO/POS Results *(see Table 15)*

- The majority of plans performed below the Maryland HMO/POS average of 28 percent, most likely because of one plan that performed significantly above the other plans, which may have skewed the average.
- HMO/POS plan rates of HMO/POS ranged from 21–56 percent.

Table 15: Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland HMO/POS Average	**28%**	
Aetna	25%	★
BlueChoice	26%	★
CIGNA	24%	★
Coventry	22%	★
Kaiser Permanente	56%	★★★
M.D. IPA	21%	★
OCI	24%	★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

PPO Results *(see Table 16)*

- The rates for PPO plans ranged from 20–42 percent.
- One plan performed significantly above the Maryland average of 29 percent, while one plan received an average score, and two performed below the Maryland average.

Table 16: Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**29%**	
Aetna PPO	42%	★★★
BluePreferred	26%	★
CGLIC	28%	★★
MAMSI Life	20%	★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.

USE OF SPIROMETRY TESTING IN THE ASSESSMENT AND DIAGNOSIS OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Background

COPD is a group of diseases characterized by airflow obstruction and breathing related problems. COPD includes chronic bronchitis, emphysema, and sometimes asthma (CDC, 2003). Spirometry, a test used to measure lung air flow and volume, is an important tool in assessing the presence of COPD. Symptoms of the disorder can vary from mild (a chronic cough) to severe (disabling shortness of breath), which may lead to impairment of quality of life (National Heart, Lung, and Blood Institute, n.d.).

COPD is the fourth leading cause of death in the United States. More than 127,000 Americans died from COPD in 2005, with more fatalities among women. Smoking is the most common cause of COPD. Data estimates for 2006 show that more than 12 million U.S. adults have COPD (American Lung Association, 2008).

Although spirometry is a widely accepted and encouraged diagnostic method for COPD, new research shows it is not used enough by providers. A study assessing whether 5,039 patients with newly diagnosed COPD, from five health plans, received spirometry in the preceding 720 days, found that only 32 percent were administered the test. The study pointed out that without proper testing, both under-diagnosis and misdiagnosis can occur, leading to improper treatment (Han, Kim, Mardon, Renner, Sullivan, Diette, and Martinez, 2007).

Measure Definition

The *Use of Spirometry in the Assessment and Diagnosis of COPD* measure shows the percentage of members 40 years of age and older during the measurement year with a new diagnosis of COPD, who received spirometry testing to confirm this diagnosis.

Data Collection Methodology

This measure is collected using the Administrative Method.

Summary of Changes to HEDIS 2008

Changes to the measure include a new definition. The episode start date and new episode terms are now referred to as the Index Episode Start Date (IESD).

HMO/POS Results *(see Table 17)*

- All HMO/POS plans received average scores compared to the Maryland average.
- In 2008, there was not much variability between plans; rates ranged from 33–39 percent, with a Maryland average of 36 percent. Similar to the variability in 2007 that ranged from 33-36 percent.

Table 17: Use of Spirometry Testing in the Assessment and Diagnosis of COPD

	Comparison of Absolute Rates		Comparison of Relative Rates	
	2007	**2008**	**2007**	**2008**
Maryland HMO/POS Average	**35%**	**36%**		
Aetna	33%	37%	★★	★★
BlueChoice	36%	35%	★★	★★
CIGNA	35%	39%	★★	★★
Coventry	35%	33%	★★	★★
Kaiser Permanente	36%	36%	★★	★★
M.D. IPA	36%	36%	★★	★★
OCI	34%	36%	★★	★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION

Background

"Chronic obstructive pulmonary disease" (COPD) is the term used to classify lung conditions such as chronic bronchitis, emphysema, and asthmatic bronchitis. It is the fourth leading cause of death in the United States. The National Heart Lung and Blood Institute estimates 12 million Americans are diagnosed with COPD and another 12 million may be unaware they have the disease (2008). COPD is often caused by long-term smoking; other risk factors include long-term exposure to dust or chemicals, age, and genetics (The Mayo Clinic, 2007).

The Global Initiative for Chronic Obstructive Lung Disease (GOLD, 2007) recommends four components for effective management of COPD: assess and monitor disease, reduce risk factors, manage stable COPD, and manage exacerbations. For people with COPD, exacerbations are acute in onset and may require treatment in addition to their normal therapy (Burge, S and Wedzicha, JA, 2003). Two of the most common causes of exacerbation are infection of the trachea and bronchi, and air pollution. Evidence shows that broncho-dilators and glucocorticosteroids are effective treatments; however, to prevent future exacerbations and the progression of COPD, there should also be prescribed medication and follow-up education (GOLD, 2007).

Measure Definition

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department (ED) encounter between January 1 and December 1 of 2007 and were dispensed appropriate medications. The rates for dispensing a systemic corticosteroid within 14 days of the event and dispensing a bronchodilator within 30 days of the event are reported.

Notes

This is a first-year measure; therefore, results are reported in aggregate. The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members, so it is possible for the denominator to include multiple events for the same individual.

In 2007, NCQA identified an issue of double-counting standardized industry codes in instances when two compatible but separate code sets were used to identify inpatient visits for the denominator. If an inpatient has multiple physician encounters at the hospital, this coding may result in one stay counted in the denominator multiple times. An FAQ was issued at the time, but since it was after the October update, the change was not binding. NCQA does not know which plans followed the FAQ and which did not, nor does it know how performance rates and population sizes were affected. Specifications have been updated for HEDIS 2009.

Measure Results

On average, 57 percent of members in Maryland HMO/POS plans who were hospitalized or had an emergency department due to a COPD exacerbation were prescribed a systemic corticosteroid during 2007. On average, 66 percent of these members were dispensed a bronchodilator.

USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

Background

Asthma is the sixth leading chronic disease in the United States and the leading chronic disease among children (NCCDPHP, 2008). In 2005, asthma accounted for an estimated 12.8 million physician office visits, 1.3 million hospital outpatient department visits, and 1.8 million emergency department visits, nationally (CDC, 2006).

Asthma prevalence in Maryland is measured annually using the Behavioral Risk Factor Surveillance Survey (BRFSS). According to 2005 data, nearly 14 percent of adults and 10 percent of children have some history of asthma. In 2004, there were approximately 8,700 asthma hospitalizations and approximately 36,000 emergency department visits in Maryland for asthma. State health care expenditures related to asthma hospitalizations and emergency department visits amounted to $42 million and $21 million, respectively (Maryland Family Health Administration, 2007).

Health status of asthmatics varies based on their reported experiences. 2007 data indicate that 16 percent of adults experienced symptoms daily, and only 37 percent of adults were symptom-free in the last month. According to the survey, 45 percent of Maryland adults with asthma received no routine check-ups for their illness in the year prior to the BRFSS survey. 25 percent of Maryland asthmatics saw a doctor at least once during the year for urgent or worsening asthma symptoms. Asthma related symptoms disrupted sleep for approximately 50 percent of adults (Maryland Family Health Administration, 2007).

Asthma-related costs include direct costs such as hospitalizations, medications, and outpatient procedures, and indirect costs such as wage and productivity losses. Cisternas, Blanc, Yen, et al. (2003) studied a sample of 401 adults with asthma and determined that the annual direct medical treatment cost of asthma for the average patient was $2,697, with medications composing 60 percent of costs. When patients were grouped by severity of asthma, cost allocation shifted. For individuals with severe cases of asthma, hospital-related costs were 10–20 times higher and emergency department visits and outpatient medical procedures were 5–8 times higher, compared with those of patients with mild and moderate cases. Studies have shown that the appropriate use of inhaled corticosteroids can have positive effects on both direct and indirect costs, and their use has proven to increase symptom-free days

Measure Definition

The *Use of Appropriate Medications for People With Asthma* measure shows the percentage of members 5–56 years of age with persistent asthma, who were continuously enrolled during 2005 and 2006 and who were prescribed medications acceptable as primary therapy for long-term control of asthma. People with persistent asthma are defined by HEDIS as having had *any* of the following during 2006 and 2007.

- At least one emergency department visit with asthma as the principal diagnosis
- At least one acute inpatient discharge with asthma as the principal diagnosis

- At least four outpatient visits with asthma as one of the listed diagnoses and a minimum of two asthma medication dispensing events
- At least four asthma medication dispensing events

The medications identified as acceptable primary therapy are listed on NCQA's Web site, www.ncqa.org.

HEDIS 2008 measure results are reported for four age groups.

- 5–9 years of age
- 10–17 years of age
- 18–56 years of age
- Total

Data Collection Methodology

This measure is collected using the Administrative Method.

Summary of Changes to HEDIS 2008

Asthma medications are now separated into two tables.

HMO/POS Results *(see Tables 18–21)*

- In 2008, the rates for appropriate use of medications for people with asthma in age groups 5–17 years and 18–56 years were 96 percent and 93 percent, respectively. The variability between plans for each age group was similar; plan rates ranged from 94-98 percent for age group 5–17, and 91-97 percent for age group 18–56.
- In 2008, the majority of plans received average scores for combined ages 5–56 years; only one plan performed above the Maryland HMO/POS average and one plan performed significantly below.
- When the age group 5–17 years was separated into ages 5–9 and 10–17, one plan significantly increased its performance relative to the Maryland averages calculated for these narrower age bands. The new comparison sets resulted in performance increasing from below average to average in age group 5–9 and above average in age group 10–17. For another plan, the opposite occurred. The plan received an above-average score for age group 5–17; when ages were spilt, the plan performed below the Maryland average for ages 10–17 and average for ages 5–9.

Table 18: Use of Appropriate Medications for People With Asthma, Ages 5-17

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**94%**	**95%**	**96%**			
Aetna	90%	91%	96%	★	★	★★
BlueChoice	95%	94%	94%	★★	★★	★★★
CIGNA	95%	96%	98%	★★	★★	★★
Coventry	96%	97%	96%	★★	★★	★★
Kaiser Permanente	96%	96%	96%	★★★	★★	★★
M.D. IPA	93%	94%	95%	★★	★★	★★
OCI	94%	94%	97%	★★	★★	★

Table 19: Use of Appropriate Medications for People With Asthma, Ages 18-56

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**93%**	**93%**	**93%**			
Aetna	88%	90%	91%	★	★	★★
BlueChoice	98%	93%	92%	★★★	★★	★★
CIGNA	90%	91%	91%	★	★★	★★
Coventry	93%	95%	93%	★★	★★	★★
Kaiser Permanente	97%	96%	97%	★★★	★★★	★★★
M.D. IPA	92%	93%	92%	★★	★★	★★
OCI	91%	92%	92%	★	★★	★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Table 20: Use of Appropriate Medications for People With Asthma- Combined Age Groups

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**93%**	**94%**	**94%**			
Aetna	89%	90%	93%	★	★	★★
BlueChoice	97%	94%	93%	★★★	★★	★
CIGNA	92%	93%	93%	★	★★	★★
Coventry	94%	96%	94%	★★	★★★	★★
Kaiser Permanente	97%	96%	96%	★★★	★★★	★★★
M.D. IPA	92%	93%	93%	★★	★★	★★
OCI	92%	93%	94%	★	★★	★★

Table 21: Use of Appropriate Medications for People With Asthma, 2008 Results

Maryland HMO/POS Average	Ages 5–9		Ages 10–17		Ages 5–17		Ages 18–56	
	97%		95%		96%		93%	
Aetna	98%	★★	94%	★★	96%	★★	91%	★★
BlueChoice	97%	★★	92%	★	94%	★★★	92%	★★
CIGNA	99%	★★★	96%	★★	98%	★★	91%	★★
Coventry	97%	★★	94%	★★	96%	★★	93%	★★
Kaiser Permanente	96%	★★	96%	★★	96%	★★	97%	★★★
M.D. IPA	97%	★★	93%	★★	95%	★★	92%	★★
OCI	97%	★★	97%	★★★	97%	★	92%	★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

PPO Results *(See Tables 22-25)*

- In 2008, the average rates in age groups 5–17 years and 18–56 years were 96 percent and 93 percent, respectively. The variability between plans for each age group was similar; plan rates ranged from 93-97 percent for age group 5–17 and 91-95 percent for age group 18–56.
- In 2008, the majority of plans received average scores across age groups; only one plan performed above the Maryland PPO average for both age groups.

Table 22: Use of Appropriate Medications for People With Asthma, Ages 5-17, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**96%**	
Aetna PPO	97%	★★
BluePreferred	97%	★★★
CGLIC	93%	★★
MAMSI Life	96%	★★

Table 23: Use of Appropriate Medications for People With Asthma, Ages 18-56, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**93%**	
Aetna PPO	92%	★★
BluePreferred	95%	★★★
CGLIC	94%	★★
MAMSI Life	91%	★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.

Table 24: Use of Appropriate Medications for People With Asthma, Combined Age Groups, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**94%**	
Aetna PPO	93%	★★
BluePreferred	95%	★★★
CGLIC	94%	★★
MAMSI Life	93%	★★

Table 25: Use of Appropriate Medications for People With Asthma, 2008 Results

	Ages 5-9		Ages 10-17		Ages 5-17		Ages 18-56	
Maryland PPO Average	**95%**		**96%**		**96%**		**93%**	
Aetna PPO	99%	★★★	94%	★★	97%	★★	92%	★★
BluePreferred	96%	★★	97%	★★	97%	★★★	95%	★★★
CGLIC	92%	★★	94%	★★	93%	★★	94%	★★
MAMSI Life	92%	★★	99%	★★	96%	★★	91%	★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.

COLORECTAL CANCER SCREENING

Background

In the United States, colorectal (colon) cancer is the second leading cause of cancer deaths. Both men and women are at risk; among men it is the third most common cancer after prostate and lung cancer, and among women it is the third most common cancer following breast and lung cancers (CDC, 2008). From 2000–2004, out of 50 states and the District of Columbia, the state of Maryland had the 13th highest mortality rate for colorectal cancer (MMWR, 2007).

Colorectal cancer is usually the result of abnormal growths, or polyps, in the colon or rectum. Various screening methods can find colorectal cancer in its earlier stages and precancerous growths before they turn into cancer, making treatment more effective (CDC, 2008). Both the American Cancer Society and the U.S. Preventive Services Task Force recommend that adults begin screening at age 50, or before 50 if at increased risk for developing colorectal cancer (MMWR, 2007).

Screenings for colorectal cancer include fecal occult blood test (FOBT), sigmoidoscopy and colonoscopy, double contrast barium enema (DCBE), and digital rectal exam (National Cancer Institute, n.d.). According to the CDC, around 60 percent of deaths from colorectal cancer would be prevented if all individuals age 50 and older had regular screenings.

Nationally, colorectal cancer incidence rates have decreased for most of the last 20 years (66.3 cases per 100,000 people in 1985 to 48.2 per 100,000 people in 2004). This decline can be partially attributed to the increase in screenings (American Cancer Society, 2008). From 2002–2006, the number of Maryland adults who reported not having a colorectal cancer test decreased from 25.9 percent to 19.8 percent (MMWR, 2007).

Measure Definition

The *Colorectal Cancer Screening* measure shows the percentage of adults 50–80 years of age who had appropriate screening for colorectal cancer.

Data Collection Methodology

This measure is collected using the Hybrid Method.

Summary of Changes to HEDIS 2008

There were coding changes made to the measure.

Notes

For this measure, the numerator includes one or more screenings for colorectal cancer. Appropriate screenings must meet one of four criteria. People who meet multiple criteria factor into the rate only once.

- FOBT during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.

- DCBE during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

HMO/POS Results *(see Table 26)*

- The rates of colorectal cancer screenings for three of the HMO/POS plans significantly increased between 2006 and 2008.
- The Maryland average increased by 3 percentage points and two plans performed significantly above the average.

Table 26: Colorectal Cancer Screening, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**55%**	**57%**	**58%**	**3%**			
Aetna[m]	52%	54%	56%	↑	★	★★	★
BlueChoice	54%	55%	58%	⇔	★★	★★	★★
CIGNA	60%	64%	68%	↑	★★★	★★★	★★★
Coventry[m]	56%	57%	45%	↓	★★	★★	★
Kaiser Permanente[m]	53%	58%	61%	↑	★	★★	★★★
M.D. IPA	59%	59%	61%	⇔	★★★	★★★	★★
OCI	53%	53%	56%	⇔	★	★	★★

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- [m]This plan used the Administrative Method to calculate this rate.

BREAST CANCER SCREENING

Background

Breast cancer is the most frequently diagnosed cancer in women. Though breast cancer is more common in women, men are also at risk of developing the disease. In 2008, an estimated 182,460 new cases of invasive (cancer that has spread beyond the tissue in which it originally developed) breast cancer are expected to occur among women and 1,990 new cases among men in the U.S (American Cancer Society, 2008).

Mammograms (x-rays of the breast tissue) typically find cancerous cells at earlier, more treatable stages, before a health professional or individual can feel any changes (Centers for Disease Control, 2006). Research findings suggest the combination of early detection through mammograms, improvements in available treatments, and decrease in use the of hormone replacement therapy (HRT) have led to a decline in breast cancer mortality. On average, a mammogram can detect from 80 percent–90 percent of breast cancers in women who do not have any symptoms (American Cancer Society, 2008). Though there is no proof that HRT causes breast cancer, it has been observed that as mammography screening rates remained consistent over time, the number of women taking HRT declined, and so did the incidence of hormone related breast cancer cases (Heiss, et al, 2008).

Measure Definition

The *Breast Cancer Screening* measure shows the percentage of women 40–69 years of age, who were continuously enrolled during 2006 and 2007, and who had at least one mammogram during those years.

Data Collection Methodology

This measure is collected using the Administrative Method.

Summary of Changes to HEDIS 2008

Coding changes were made to this measure.

Notes

- This measure reports two age stratifications (42–51 years, 52–69 years) and a total rate. Numerator requirements include individuals who had one or more mammograms during the measurement year or the year prior to the measurement year.
- The Hybrid Method was retired in HEDIS 2006, so trending performance over time should be considered with caution.

HMO/POS Results *(see Table 27)*

- Between 2006 and 2008, every HMO/POS plan significantly decreased its rates of breast cancer screenings. The Maryland average decreased by four percentage points over this period.
- One plan performed above the Maryland average, while three plans received average scores, and three plans performed below average.

Table 27: Breast Cancer Screening, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**71%**	**69%**	**68%**	**-4%**			
Aetna	68%	66%	66%	🡻	★	★	★
BlueChoice	71%	67%	65%	🡻	★	★	★
CIGNA	69%	66%	68%	🡻	★	★	★★
Coventry	73%	70%	68%	🡻	★★★	★★★	★★
Kaiser Permanente	78%	77%	75%	🡻	★★★	★★★	★★★
M.D. IPA	73%	69%	68%	🡻	★★★	★★	★★
OCI	68%	65%	64%	🡻	★	★	★

Legend

Change 2006–2008

🡹 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡻 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

PPO Results *(see Table 28)*

- In 2008, the Maryland PPO plan average was 63 percent. The individual plan rates ranged from 58–66 percent.
- Two health plans received scores above the Maryland PPO average, one plan received an average score, and one plan received a below-average score.

Table 28: Breast Cancer Screening, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**63%**	
Aetna PPO	65%	★★★
BluePreferred	58%	★
CGLIC	63%	★★
MAMSI Life	66%	★★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.

CERVICAL CANCER SCREENING

Background

In 2008, the National Cancer Institute estimates there will be 11,070 new cases, and 3,870 deaths from cervical cancer (American Cancer Society, 2008). Of all cancers that women are at risk for developing, cervical cancer is one of the easiest to prevent. The Pap test (Pap smear) and the human papillomavirus (HPV) test are two methods used to screen for cervical cancer. The Pap test can find precancerous cells or changes in the cervix that may develop into cancer if not treated. An HPV test is used to test the presence of the virus that causes changes in cells (CDC, 2008). Like many cancers, early detection of cervical cancer is critical—cervical cancer rarely causes pain or noticeable symptoms until advanced stages, when it is less responsive to treatment (Food and Drug Administration, 2006).

Previously, cervical cancer was a leading cause of cancer deaths among women in the United States, but because more women obtain regular Pap tests, both the incidence and mortality has declined (CDC, 2008). In Maryland, cervical cancer mortality rates are estimated at 2.5 deaths per 100,000 women (U.S. Cancer Statistics Working Group, 2007).

Measure Definition

The *Cervical Cancer Screening* measure shows the percentage of women 21–64 years of age, who were continuously enrolled from 2005–2007, and who received one or more Pap tests during those years.

Data Collection Methodology

This measure is collected using either the Administrative Method or the Hybrid Method. This measure was eligible for rotation in HEDIS 2008.

Summary of Changes to HEDIS 2008

Coding changes made to this measure do not affect comparability to prior years' results in this report.

HMO/POS Results *(see Table 29)*

- The Maryland HMO/POS average declined one point over the 2006–2008 time period.
- The majority of plans received average scores compared to the Maryland average; two plans received below average scores.

Table 29: Cervical Cancer Screening, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**83%**	**81%**	**82%**	**-1%**			
Aetna[m]	85%	79%	79%	🡻	★★	★	★
BlueChoice	84%	79%	83%	⇔	★★	★	★★
CIGNA[r]	84%	84%	84%	⇔	★★	★★	★★
Coventry[r]	82%	80%	80%	⇔	★★	★★	★★
Kaiser Permanente[r]	81%	82%	82%	🡹	★	★★★	★★
M.D. IPA	83%	83%	83%	⇔	★★	★★	★★
OCI[m]	81%	78%	78%	⇔	★★	★	★

Legend

Change 2006–2008

🡹 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡻 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- [m]This plan used the Administrative Method to calculate this rate.
- [r]This measure was eligible for rotation in 2008 and this plan elected to resubmit 2007 data in 2008.

CHLAMYDIA SCREENING IN WOMEN

Background

According to U.S. Preventive Services Task Force (USPSTF), chlamydia infection is the most common sexually transmitted bacterial infection in the United States. The CDC suggests annual chlamydia screenings for sexually active women 26 years and younger. If the infection goes untreated, serious short-term and long-term complications can occur. Chlamydia places women at risk for developing urethritis, cervicitis, pelvic inflammatory disease (PID), infertility, ectopic pregnancy and chronic pelvic pain (USPSTF, AHRQ, 2007).

In 2006, over 1 million cases of chlamydia infections were reported in the United States. Total cases exceed this figure by more than double, resulting in an estimated 2,291,000 Americans 14–39 years of age infected, based on the U.S. National Health and Nutrition Examination Survey (Chlamydia—CDC Fact Sheet, 2007). In Maryland, 390 cases per 100,000 residents were reported (STD Surveillance 2007).

Measure Definition

The *Chlamydia Screening in Women* measure shows the percentage of sexually active women between the ages of 16–25, continuously enrolled in their health plan during 2007, and had at least one test for chlamydia during the measurement year.

Data Collection Methodology

This measure is collected using the Administrative Method.

Summary of Changes to HEDIS 2008

Coding changes made to this measure do not affect comparability to prior years' results included in this report.

Notes

- There are two methods to identify sexually active women for inclusion in the measure: through pharmacy data or through medical claims/encounter data.
- Several factors complicate calculating this measure and can influence results. When interpreting results, readers should consider the following.
  - Pharmacy data and claims/encounter data cannot be used to identify all women who are sexually active, but can be used to identify only those who receive care related to sexual activity, such as prescriptions for contraceptives and pregnancy-related care. The actual number of women at risk is much larger than the number screened. The percentage of women being screened by some plans is only a small fraction of those who meet the criteria for screening.

HMO/POS Results

Chlamydia Screening (see Tables 30-32)

- Between 2006 and 2008, the Maryland HMO/POS average decreased one percentage point for screening for ages 16–20 years and increased one percentage point for screening for ages 21–25 years.
- In 2008, one plan performed above the Maryland HMO/POS average for all three age categories (16–20, 21–25, and 16–25). This same plan experienced a significant rate decrease between 2006 and 2008.
- Five plans performed below the Maryland average score for each age category.

Table 30: Chlamydia Screening Ages 16-20, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**43%**	**43%**	**42%**	**-1%**			
Aetna	42%	42%	39%	🡻	★	★★	★
BlueChoice	35%	37%	42%	🡹	★	★	★★
CIGNA	35%	39%	39%	🡹	★	★	★
Coventry	40%	39%	39%	⇔	★	★	★
Kaiser Permanente	72%	68%	67%	🡻	★★★	★★★	★★★
M.D. IPA	41%	39%	36%	🡻	★	★	★
OCI	37%	35%	33%	🡻	★	★	★

Legend

Change 2006–2008

🡹 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡻 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Table 31: Chlamydia Screening Ages 21-25, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**44%**	**44%**	**45%**	**1%**			
Aetna	40%	41%	39%	⇔	★	★	★
BlueChoice	36%	39%	44%	🡅	★	★	★★
CIGNA	35%	37%	40%	🡅	★	★	★
Coventry	39%	40%	41%	⇔	★	★	★
Kaiser Permanente	79%	76%	75%	🡇	★★★	★★★	★★★
M.D. IPA	40%	41%	38%	⇔	★	★	★
OCI	38%	36%	36%	⇔	★	★	★

Table 32: Chlamydia Screening Ages 16-25, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**43%**	**44%**	**43%**	**0%**			
Aetna	41%	41%	39%	🡇	★	★	★
BlueChoice	35%	38%	43%	🡅	★	★	★★
CIGNA	35%	38%	40%	🡅	★	★	★
Coventry	39%	39%	40%	⇔	★	★	★
Kaiser Permanente	76%	72%	71%	🡇	★★★	★★★	★★★
M.D. IPA	41%	40%	37%	🡇	★	★	★
OCI	37%	36%	35%	🡇	★	★	★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

CONTROLLING HIGH BLOOD PRESSURE

Background

An estimated 73 million people have high blood pressure, also known as hypertension, in the United States (CDC, 2008). High blood pressure is characterized by a systolic pressure ≥140 mm Hg or a diastolic pressure ≥90 mm Hg (Rosamond, Flegal, Furie, Go, Greenlund, Haase, et al., 2008). One third of people do not have recognizable symptoms and are therefore unaware they have high blood pressure. Uncontrolled hypertension places individuals at risk for stroke, heart attack, and heart or kidney failure (American Heart Association, 2008). According to the 2007 Behavioral Risk Factor Surveillance System, about 29 percent of adults in Maryland were told they had high blood pressure (BRFSS, 2007).

According to the seventh report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7), individuals with a blood pressure of ≤120/80 mm Hg should be screened every other year, while those with a reading of from 120–139/80–90 mm Hg be screened every year (U.S. Preventive Services Task Force, 2007).

Measure Definition

The *Controlling High Blood Pressure* measure shows the percentage of members 18–85 years of age who were continuously enrolled in 2007 and were diagnosed with hypertension. "Adequate control" was defined as a blood pressure reading of <140/90 mm Hg during the past year. Both systolic and diastolic pressure must be at or under this threshold for blood pressure to be considered controlled.

Data Collection Methodology

This measure is collected using the Hybrid Method. This measure was eligible for rotation in HEDIS 2008.

Summary of Changes to HEDIS 2008

Changes to the codes, measure specifications, and age stratifications inhibit comparability to prior years' results.

HMO/POS Results *(see Table 33)*

- HMO/POS plans received rates from 54 to 76 percent in 2008. The Maryland average was 63 percent; three plans performed significantly better than this rate.

Table 33: Controlling High Blood Pressure

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**73%**	**59%**	**63%**			
Aetna	71%	51%	60%	★★	★	★
BlueChoice[r]	70%	68%	68%	★★	★★★	★★★
CIGNA[r]	81%	76%	76%	★★★	★★★	★★★
Coventry[r]	65%	61%	61%	★	★★★	★
Kaiser Permanente[r]	77%	65%	65%	★★	★★★	★★★
M.D. IPA	76%	48%	54%	★★	★	★
OCI	71%	46%	57%	★★	★	★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- Results for this measure cannot be trended to prior years' results because of measure specification changes.
- [r]This measure was eligible for rotation in 2008 and this plan elected to resubmit 2007 data in 2008.

PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

Background

More American men and women die from coronary heart disease (CHD) than from any other disease. According to the National Health and Nutrition Examination Survey, an estimated 8,100,000 Americans have suffered a heart attack, or myocardial infarction (AMI), at one point in their lives. Studies estimate that in 2008, 600,000 individuals will have their first heart attack and 320,000 will suffer a recurrent episode (*NHLBI: Based on unpublished data from the ARIC and CHS Studies,* American Heart Association, 2008). Each year, about half of those who suffer a heart attack die (NIH, NHLBI, 2008).

To reduce the mortality during acute and long-term management of heart attacks, the American Heart Association and the American College of Cardiology strongly recommend treatment using beta-blockers. Beta-blockers prevent blockage in the artery and have been shown to reduce the risk of sudden cardiac death by up to 50 percent in patients who recently suffered a heart attack (AHA, 2002).

Though it is well proven that long-term beta-blocker treatment improves outcomes following a heart attack, most patients stop taking the medication after just a few months of the episode. An analysis of long-term beta-blocker adherence among 17,035 patients who survived at least one year after a heart attack showed that in the year after hospital discharge, only 45 percent of the patients adhered to their beta-blocker therapy, and adherence fell most dramatically between 30 and 90 days after discharge (Kramer et al., 2006).

Measure Definition

The *Persistence of Beta-Blocker Treatment After a Heart Attack* measure shows the percentage of members 18 years of age and older who were hospitalized and discharged alive with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Data Collection Method

This measure is collected using the Administrative Method.

Summary of Changes to HEDIS 2008

The lower age limit is decreased from 35 years to 18 years in HEDIS 2008; the change does not affect comparability to prior years' results included in this report.

Notes

- When interpreting these rates, readers should understand that plans may exclude any member identified as having a contraindication or previous adverse reaction to beta-blocker therapy.

HMO/POS Results *(see Table 34)*

- The Maryland HMO/POS rate increased 5 percentage points between 2006 and 2008; five plans demonstrated no significant change in rate over this period. Two plans significantly increased their rates between 2006 and 2008.
- Six of the seven plans received average scores in relation to the Maryland average of 73 percent, while one plan received a below-average score.

Table 34: Persistence of Beta-Blocker Treatment After a Heart Attack, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**68%**	**75%**	**73%**	**5%**			
Aetna	64%	65%	66%	⇔	★★	★	★
BlueChoice	56%	65%	71%	🡅	★	★	★★
CIGNA	68%	74%	67%	⇔	★★	★★	★★
Coventry	75%	82%	78%	⇔	★★	★★	★★
Kaiser Permanente	80%	76%	76%	⇔	★★★	★★	★★
M.D. IPA	68%	81%	78%	⇔	★★	★★	★★
OCI	68%	80%	76%	🡅	★★	★★	★★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

PPO Results *(see Table 35)*

- In 2008, the Maryland PPO average was 71 percent. PPO rates ranged from 59–85 percent. One plan performed significantly above the Maryland average.

Table 35: Persistence of Beta-Blocker Treatment After a Heart Attack, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**71%**	
Aetna PPO	59%	★
BluePreferred	68%	★★
CGLIC	74%	★★
MAMSI Life	85%	★★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.

CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS

Background

High levels of low-density lipoprotein (LDL) and overall high levels of blood cholesterol are linked to coronary artery disease, also known as coronary heart disease (CHD) (AHRQ, 2008). Studies have shown that individuals with heart disease who take steps to lower their cholesterol can reduce their risk of dying from heart disease, having a heart attack, or undergoing bypass surgery or angioplasty (CDC, 2005).

Total cholesterol <150 mg/dL is protective and associated with a decrease in CHD. According to the CDC (2008), a decrease of 10 percent in cholesterol levels among the United States population could result in a 30 percent decrease in heart disease. High cholesterol does not have any symptoms, which means that many people are unaware that they have high cholesterol. Blood tests are used to screen LDL and high-density lipoprotein (HDL) cholesterol levels, as well as triglycerides, the body's fat supply for energy.

National Cholesterol Education Program (NCEP) guidelines recommend an "optional" goal for LDL levels of <70 mg/dL for very high-risk patients, or individuals with CHD and one of four conditions (diabetes mellitus; severe or poorly controlled risk factors such as smoking; multiple risk factors of metabolic syndrome; acute coronary syndrome). NCEP recommends LDL levels of <100 mg/dL for those with moderate to high risk. Results from a number of clinical trials support implementation of an intensive treatment to further reduce LDL levels to <70 mg/dL among high risk populations as an effective means of preventing the occurrence of future cardiovascular events (Neal & Jones, 2006).

Measure Definition

The *Cholesterol Management For Patients With Cardiovascular Conditions* measure shows the percentage of members 18–75 years of age who were hospitalized and discharged alive during the 2007 measurement year after an AMI, coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA), *or* who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior. For these members, the following two rates are calculated.

- The percentage who received a cholesterol (LDL-C) screening within the measurement year
- The percentage who had a cholesterol (LDL-C) level of <100 mg/dL within the measurement year

Data Collection Methodology

This measure is collected using either the Administrative or Hybrid Method.

Summary of Changes to HEDIS 2008

There are no changes to this measure.

HMO/POS Results *(see Table 36 and 37)*

- In 2008, plan scores ranged from 81-92 percent for LDL-C screening. Five plans received an average score and one plan received a below and one an above-average score.
- In 2008, plan scores ranged from 46-68 percent for LDL-C control. Five plans received an average score and one plan received a below and one an above-average score.

Table 36: Cholesterol Management, Cholesterol (LDL-C) Screening

	Comparison of Absolute Rates		Comparison of Relative Rates	
	2007	2008	2007	2008
Maryland HMO/POS Average	**85%**	**85%**		
Aetna	82%	83%	★★	★★
BlueChoice[m]	78%	81%	★	★
CIGNA	90%	92%	★★★	★★★
Coventry	83%	82%	★★	★★
Kaiser Permanente	84%	88%	★★	★★
M.D. IPA	87%	85%	★★	★★
OCI	87%	84%	★★	★★

Table 37: Cholesterol Management, Cholesterol (LDL-C) <100mg/dL Control

	Comparison of Absolute Rates		Comparison of Relative Rates	
	2007	2008	2007	2008
Maryland HMO/POS Average	**58%**	**58%**		
Aetna	58%	54%	★★	★★
BlueChoice[m]	46%	46%	★	★
CIGNA	59%	68%	★★	★★★
Coventry	63%	56%	★★★	★★
Kaiser Permanente	58%	62%	★★	★★
M.D. IPA	61%	58%	★★	★★
OCI	60%	60%	★★	★★

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- [m]This plan used the Administrative Method to calculate this rate.

COMPREHENSIVE DIABETES CARE

Background

An estimated 17 million people have been diagnosed with diabetes, and 5.7 million individuals are unaware they have the disease (NIH, NIDDK, 2008). Additionally, 57 million Americans have pre-diabetes, a condition that occurs when blood glucose levels are higher than normal, though still below diabetic levels. The rate of diabetes tends to increase with age According to the American Diabetes Association, around 7.9 percent of Americans 45–54 years of age have diagnosed diabetes, while 17.6 percent of those 65 and older have been diagnosed (American Diabetes Association, n.d.).

The prevalence of diabetes in the U.S. has a significant economic affect. The estimated overall cost of diabetes totaled $174 billion in 2007. Of this, $116 billion was spent on medical costs and $58 billion resulted from reduced productivity (absenteeism, unemployment due to chronic disability, decreased productivity at work and at home and mortality). An additional $58 billion was spent in 2007 treating diabetes-related chronic conditions (American Diabetes Association, 2008).

In Maryland, 334,000 (8 percent) of adults reported they had been diagnosed with diabetes in 2006 and 143,000 adults were predicted to have undiagnosed diabetes. In 2005, there were 9,344 hospitalizations and over 29,000 emergency department visits for a primary diagnosis of diabetes (Maryland Department of Health and Mental Hygiene, 2007). Nationally, among adults with diabetes, 84 percent reported taking medication (i.e., insulin or oral medications) for their condition (CDC, 2007).

Measure Definition

The *Comprehensive Diabetes Care* measure assesses recommended care received by and intermediate outcomes of members 18–75 years of age who have diabetes (types 1 and 2) and were continuously enrolled during 2007. Percentages were calculated for each of the following.

- Hemoglobin A1c (HbA1c) testing
- HbA1c control (<9.0 percent)
- Eye exam (retinal) performed
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for nephropathy
- Blood pressure control (<130/80 mm Hg and <140/90 mm Hg)

Maryland health plans also report a *Comprehensive Diabetes Care—Combination Rate*, which is the percentage of members with diabetes who receive recommended care and have good levels of the blood constituents described above.

Data Collection Methodology

This measure is collected using the Administrative Method or the Hybrid Method. For this measure only, a plan may report only the administrative rate collected on the sample and opt not to perform medical record review.

Summary of Changes to HEDIS 2008

Changes to this measure include coding changes and the addition of various medications. Clarifications were made regarding the best method to identify the medical record from which to abstract the blood pressure level; organizations should not use a blood pressure reading from an acute inpatient stay. Changes affect comparability for the cholesterol measures, nephropathy measure, blood control measures, and composite measure; they do not affect comparability to prior years' results for the blood glucose measures and eye exam measure.

Notes

Methods used to identify members with diabetes can influence final rates. NCQA requires plans to identify diabetics using pharmacy and encounter data. "Encounters" are no-charge claims sent to the plan when a member sees a provider. Pharmacy data alone tend to exclude people with type 2 diabetes, since medication is not always necessary. Relying on encounter data alone tends to find more false-positives or members who are incorrectly identified as diabetic. Use of both methods may improve the accuracy of the population used to calculate the rate for each plan.

HMO/POS Results

Blood Glucose Monitoring and Control (see Tables 38 and 39)

- The Maryland HMO/POS average for blood glucose (HbA1c) monitoring remained unchanged between 2006 and 2008. None of the plan rates changed significantly between 2006 and 2008. One plan received an above-average score in comparison to the Maryland HMO/ POS average, while the remainder of the plans received average scores.
- The Maryland HMO/POS average rate decreased point for HbA1c control between 2006 and 2008. One plan significantly increased its rate over the three-year period, while four plans did not change, and one plan significantly decreased its rate. Two plans performed significantly better than the Maryland HMO/POS average and one plan scored significantly below; the remainder of the plans received average scores.

Table 38: Comprehensive Diabetes Care, Blood Glucose (HbA1c) Testing, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**85%**	**86%**	**85%**	**0%**			
Aetna	86%	85%	84%	⇔	★★	★★	★★
BlueChoice	83%	88%	84%	⇔	★★	★★	★★
CIGNA	90%	93%	93%	⇔	★★★	★★★	★★★
Coventry	84%	84%	85%	⇔	★★	★★	★★
Kaiser Permanente	85%	87%	83%	⇔	★★	★★	★★
M.D. IPA	85%	85%	83%	⇔	★★	★★	★★
OCI	83%	80%	83%	⇔	★★	★	★★

Table 39: Comprehensive Diabetes Care, Blood Glucose (HbA1c) Control, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**71%**	**70%**	**70%**	**-1%**			
Aetna	67%	66%	67%	⇔	★★	★★	★★
BlueChoice	70%	76%	77%	🡅	★★	★★★	★★★
CIGNA	73%	76%	78%	⇔	★★	★★★	★★★
Coventry	66%	68%	67%	⇔	★	★★	★★
Kaiser Permanente	77%	73%	65%	🡇	★★★	★★	★
M.D. IPA	73%	69%	68%	⇔	★★	★★	★★
OCI	70%	63%	69%	⇔	★★	★	★★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Cholesterol Monitoring and Control (see Tables 40 and 41)

- In 2008, six of the seven HMO/POS plans received average scores, with rates ranging from 79-90 percent for cholesterol (LDL-C) testing. One plan received an above-average score, with a rate of 90 percent. The Maryland average for 2008 was 83 percent.
- For cholesterol control, the rates of HMO/POS plans ranged from 41–65 percent. The Maryland average was 46 percent. One plan received an above-average score, three plans received average scores, and three plans received below-average scores.

Table 40: Comprehensive Diabetes Care, Cholesterol (LDL-C) Testing

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**91%**	**83%**	**83%**			
Aetna	90%	82%	82%	★★	★★	★★
BlueChoice	91%	86%	82%	★★	★★	★★
CIGNA	93%	87%	90%	★★	★★★	★★★
Coventry	91%	81%	83%	★★	★★	★★
Kaiser Permanente	91%	84%	81%	★★	★★	★★
M.D. IPA	91%	84%	81%	★★	★★	★★
OCI	90%	80%	79%	★★	★★	★★

Table 41: Comprehensive Diabetes Care, Cholesterol (LDL-C) <100 mg/dL Control

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**49%**	**48%**	**46%**			
Aetna	43%	45%	43%	★	★★	★★
BlueChoice	54%	56%	65%	★★★	★★★	★★★
CIGNA	47%	46%	47%	★★	★★	★★
Coventry	40%	50%	45%	★	★★	★★
Kaiser Permanente	55%	47%	41%	★★★	★★	★
M.D. IPA	52%	45%	41%	★★	★★	★
OCI	50%	44%	41%	★★	★★	★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Annual Eye Exam (see Table 42)

- None of the HMO/POS plans eye exam rates changed significantly from 2006–2008. The Maryland average decreased 2 percentage points over this period. Plan rates ranged from 48–64 percent. Two plans received scores significantly above the Maryland average; two plans had performance equivalent to the Maryland average; three plans performed below the Maryland average.

Table 42: Comprehensive Diabetes Care, Eye Exams, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**57%**	**56%**	**56%**	**-2%**			
Aetna	54%	51%	58%	⇔	★★	★	★★
BlueChoice	55%	53%	48%	⇔	★★	★★	★
CIGNA	53%	55%	58%	⇔	★	★★	★★
Coventry	55%	54%	49%	⇔	★★	★★	★
Kaiser Permanente[m]	66%	64%	63%	⇔	★★★	★★★	★★★
M.D. IPA	67%	62%	64%	⇔	★★★	★★★	★★★
OCI	53%	52%	51%	⇔	★	★★	★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- [m]This plan used the Administrative Method to calculate this rate.

Kidney Disease Monitoring (see Table 43)

- The Maryland average for nephropathy screening was 80 percent in 2008. Rates for each plan ranged from 73-91 percent. In 2008, one plan received an above-average score, four plans received average scores, and two plans received below-average scores.

Table 43: Comprehensive Diabetes Care, Medical Attention for Diabetic Nephropathy

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**56%**	**79%**	**80%**			
Aetna	51%	79%	80%	★	★★	★★
BlueChoice	52%	76%	73%	★★	★★	★
CIGNA	54%	80%	83%	★★	★★	★★
Coventry	55%	78%	82%	★★	★★	★★
Kaiser Permanente	70%	89%	91%	★★★	★★★	★★★
M.D. IPA	56%	80%	77%	★★	★★	★★
OCI	53%	74%	76%	★★	★	★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Blood Pressure Control (see Table 44 and 45)

- The Maryland averages for blood pressure control <130/80 mm Hg and control <140/90 mm Hg were 30 percent and 59 percent, respectively. For control <130/80 mm Hg, plan rates ranged from 20-41 percent. For control <140/90 mm Hg, plan rates ranged from 51-76 percent.

Table 44: Comprehensive Diabetes Care, Blood Pressure Control <130/80 mm Hg, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland HMO/POS Average	**30%**	
Aetna	25%	★
BlueChoice	40%	★★★
CIGNA	41%	★★★
Coventry	25%	★
Kaiser Permanente	34%	★★★
M.D. IPA	20%	★
OCI	25%	★

Table 45: Comprehensive Diabetes Care, Blood Pressure control <140/90 mm Hg, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland HMO/POS Average	**59%**	
Aetna	54%	★★
BlueChoice	57%	★★
CIGNA	76%	★★★
Coventry	58%	★★
Kaiser Permanente	63%	★★★
M.D. IPA	51%	★
OCI	52%	★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

MHCC Combination Rate (see Table 46)

- The majority of plans received average scores for the comprehensive diabetes combination rates. One plan received an above-average score for high performance and one plan received a below-average score for low performance.
- HMO/POS plan rates ranged from 7–13 percent. The Maryland average was 10 percent.

Table 46: Comprehensive Diabetes Care MHCC, Combined Results

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**22%**	**13%**	**10%**			
Aetna	18%	11%	8%	★★	★★	★★
BlueChoice	19%	15%	13%	★★	★★	★★★
CIGNA	21%	15%	13%	★★	★★	★★
Coventry	15%	17%	10%	★	★★★	★★
Kaiser Permanente	43%	20%	9%	★★★	★★★	★★
M.D. IPA	19%	8%	10%	★★	★	★★
OCI	16%	4%	7%	★	★	★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

FLU SHOTS FOR ADULTS AGES 50–64

Background

Each year, between 5 percent and 20 percent of Americans get the flu. More than 200,000 people are hospitalized and an estimated 36,000 people die due to flu complications (CDC, 2008). Children have the highest rate of flu infection, though serious illness and death rates are highest among people 64 years and older, people with chronic medical conditions, and children younger than two years of age (MMWR, 2006).

The influenza vaccination is the primary method used to prevent flu and its complications. A flu vaccine's effectiveness can depend on whether it matches the strains of the present virus. During the 2007-2008 flu season in the United States, provisional study results showed the overall vaccine effectiveness to be 44 percent; a "well-matched" vaccine will have effectiveness between 70 percent and 90 percent. Compared to the three prior seasons, the 2007-2008 flu season experienced a larger proportion of flu-related deaths and hospitalizations among children 4 years of age and younger (CDC, 2008).

Measure Definition

The *Flu Shots for Adults Ages 50–64* measure shows the percentage of members 50–64 years of age as of September 1, 2007, who received an influenza vaccination between September 2007 and the date on which the CAHPS 4.0H Adult Survey was completed.

Data Collection Methodology

This measure is collected through the CAHPS 4.0H survey.

Summary of Changes to HEDIS 2008

This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2008, Volume 3: Specifications for Survey Measures.*

Notes

- This measure is collected for two consecutive years to achieve a sufficient denominator. Results are calculated as a moving or rolling average using data collected during the measurement year and the year preceding the measurement year (i.e., the 2006 and 2007 data combine to form one rate).

HMO/POS Results *(see Tables 47 and 48)*

- Between 2006 and 2008, the majority of plans significantly increased their rates of flu shots for adults 50–64; only two plans experienced no significant increase. During this period, the Maryland HMO/POS average increased by 13 percentage points.
- One plan performed significantly above the Maryland average, while five received average scores, and one plan received a below-average score.
- On average for each plan, most people did not receive a flu shot because they did not ask for one. The Maryland average for people who did not ask was 56 percent.

Table 47: Flu Shots for Adults 50-64, Trending

Flu Shots for Adults 50–64, Trending							
	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**36%**	**46%**	**49%**	**13%**			
Aetna	37%	41%	46%	⇔	★★	★★	★★
BlueChoice	35%	46%	43%	⇔	★★	★★	★
CIGNA	29%	45%	52%	🡅	★	★★	★★
Coventry	33%	42%	47%	🡅	★★	★★	★★
Kaiser Permanente	45%	55%	57%	🡅	★★★	★★★	★★★
M.D. IPA	41%	49%	52%	🡅	★★	★★	★★
OCI	33%	42%	44%	🡅	★★	★★	★★

Table 48: Reasons for Not Getting a Flu Shot, 2008 Results All Response Options

Reasons for Not Getting a Flu Shot, 2008 Results					
	Didn't Ask	Refused	Ineligible	Unavailable	Other
Maryland HMO/POS Average	**56%**	**20%**	**1%**	**3%**	**20%**
Aetna	55%	23%	0%	1%	20%
BlueChoice	57%	20%	0%	3%	20%
CIGNA	57%	19%	2%	3%	21%
Coventry	60%	17%	0%	3%	20%
Kaiser Permanente	52%	26%	1%	3%	21%
M.D. IPA	54%	21%	2%	3%	21%
OCI	59%	16%	2%	3%	19%

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

PPO Results

The Maryland PPO average rate in 2006 was 53 percent. The numerator for this measure is calculated using a rolling average of two years worth of data. Since this is the first year of data collection, specific data have not been reported. Given the reasonableness of the data, plan specific results will be reported in 2009.

MEDICAL ASSISTANCE WITH SMOKING CESSATION

Background

An estimated 45 million (one in five) American adults smoke cigarettes, and 438,000 people die each year due to smoking. It is the leading cause of preventable death and disease. Consequences of smoking extend beyond an individual who smokes and include, but are not limited to, cancer, cardiovascular, and respiratory diseases; reproductive and developmental effects; pneumonia; and periodontitis. The CDC estimates that each year 3,000 Americans die of lung cancer and 35,000 of heart disease from exposure to secondhand smoke (DHHS, 2006).

Research shows that an estimated 70 percent of patients who smoke would like to quit, but only 7.9 percent can do this without help (Mallin, 2002). Evidence-based approaches, including health provider reminder systems, medications, behavioral cessation therapies, and telephone help lines have been shown to increase cessation rates. Researchers found that use of a nicotine replacement and social or behavioral support can increase the quit rate to 35 percent, while advice provided by a physician can improve the quit rate by 10.2 percent (Mallin, 2002). In Maryland smoking prevalence is estimated at 805,000 adults and 45,000 9–12th graders (DHHS, 2006).

Measure Definition

Three components make up the *Medical Assistance With Smoking Cessation* measure. For each component, members 18 years of age and older who are current smokers were asked about specific guidance from their practitioners.

1. **Advising Smokers to Quit** shows the percentage of members whose practitioner advised them to quit smoking.
2. **Discussing Smoking Cessation Medications** shows the percentage of members whose practitioner recommended or discussed smoking cessation medications.
3. **Discussing Smoking Cessation Strategies** shows the percentage of members whose practitioner recommended or discussed smoking cessation methods or strategies.

Data Collection Methodology

This measure is collected through the CAHPS 4.0H survey.

Summary of Changes to HEDIS 2008

This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2008, Volume 3: Specifications for Survey Measures.* Changes do not affect comparability to prior years' results.

Notes

This measure is collected for two consecutive years to achieve a sufficient denominator. Results are calculated as a moving or rolling average using data collected during the measurement year and the year preceding the measurement year (i.e., the 2007 and 2008 numerators and denominators are combined to form one rate).

HMO/POS Results *(see Tables 49–51)*

- The majority of plans reported NA rates because of small denominators.
- For each measure *(Advising Smokers to Quit, Discussing Cessation Medications,* and *Discussing Smoking Cessation Strategies)* only two plans were able to report eligible rates. These rates remained significantly unchanged between 2006 and 2008 for each measure and the plans received average scores compared to the Maryland average.

Table 49: Advising Smokers to Quit

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**73%**	**75%**	**78%**			
Aetna	67%	NA	NA	★★	NA	NA
BlueChoice	75%	73%	80%	★★	★★	★★
CIGNA	71%	73%	NA	★★	★★	NA
Coventry	76%	79%	76%	★★	★★	★★
Kaiser Permanente	76%	78%	NA	★★	★★	NA
M.D. IPA	76%	NA	NA	★★	NA	NA
OCI	67%	73%	NA	★★	★★	NA

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- NA = Not Applicable. Denominator is less than 100.

Table 50: Discussing Smoking Cessation Medications

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**37%**	**40%**	**47%**			
Aetna	37%	NA	NA	★★	NA	NA
BlueChoice	44%	41%	48%	★★	★★	★★
CIGNA	33%	39%	NA	★★	★★	★
Coventry	37%	39%	47%	★★	★★	★★
Kaiser Permanente	35%	43%	NA	★★	★★	NA
M.D. IPA	41%	NA	NA	★★	NA	NA
OCI	36%	37%	NA	★★	★★	NA

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- NA = Not Applicable. Denominator is less than 100.

Table 51: Discussing Smoking Cessation Strategies

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**37%**	**38%**	**47%**			
Aetna	31%	NA	NA	★★	NA	NA
BlueChoice	39%	37%	48%	★★	★★	★★
CIGNA	35%	34%	NA	★★	★★	NA
Coventry	39%	44%	46%	★★	★★	★★
Kaiser Permanente	43%	43%	NA	★★	★★	NA
M.D. IPA	40%	NA	NA	★★	NA	NA
OCI	33%	32%	NA	★★	★★	NA

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- NA = Not Applicable. Denominator is less than 100.

PPO Results

- The denominator for this measure is calculated using a rolling average of two years worth of data. Since this is the first year of data collection for PPO health plans, specific data are not reported. Given the reasonableness of the data and adequate denominator sizes, plan specific results will be reported in 2009. In 2008, all plans had insufficient denominators to calculate the single year average

DISEASE MODIFYING ANTI-RHEUMATIC DRUG THERAPY FOR RHEUMATOID ARTHRITIS

Background

Rheumatoid arthritis (RA), a chronic disease characterized by inflammation of the joint lining, affects 1.3 million Americans. It can lead to long-term joint damage, which causes chronic pain, loss of function, and disability. Early diagnosis and treatment are successful in mediating complications (Arthritis Foundation, 2008).

All races are at risk for developing rheumatoid arthritis; women have twice the risk for developing the disease as men. The onset of the disease most often occurs during middle age (National Institute of Arthritis and Musculoskeletal and Skin Diseases, 2006).

The use of disease-modifying anti-rheumatic drugs (DMARD) can slow down the progression of the disease and reduce inflammation and long-term joint damage, thus improving functionality and quality of life (Saag, DK et al., 2008). Research has shown that DMARD treatment within the first 3–9 months after diagnosis is associated with less pain, damage, and disability (Bukhari MS, et al., 2003). Consistent use of DMARDs can reduce long-term disability up to 30 percent (Fries JF, et al., 2005).

Measure Definition

The *Disease Modifying Anti-Rheumatic Therapy in Rheumatoid Arthritis* measure assesses whether patients diagnosed with RA have been prescribed at least one disease modifying anti-rheumatic drug.

Data Collection Methodology

This measure is collected using the Administrative Method.

Summary of Changes to HEDIS 2008

Changes made to the measure include adding anchor date criteria, adding codes, and deleting the "total exclusions" data element from Table ART-1/2/3. Changes do not affect comparability to prior years' results.

HMO/POS Results *(see Table 52)*

- In 2008, health plan rates for anti-rheumatic drug therapy in rheumatoid arthritis ranged from 80–89 percent.
- The Maryland HMO/POS average was 84 percent, which shows a four percentage point increase since 2006.
- One plan scored above the Maryland average, while three plans received average scores, and two plans received below-average scores.

Table 52: Disease Modifying Anti-Rheumatic Therapy in Rheumatic Arthritis, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**80%**	**83%**	**84%**	**4%**			
Aetna	79%	81%	80%	⇔	★★	★★	★
BlueChoice	73%	78%	81%	🡅	★	★	★
CIGNA	85%	86%	87%	⇔	★★★	★★	★★
Coventry	86%	91%	89%	⇔	★★	★★★	★★
Kaiser Permanente	77%	76%	85%	🡅	★★	★	★★
M.D. IPA	82%	86%	89%	🡅	★★	★★★	★★★
OCI	78%	83%	80%	⇔	★★	★★	★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

Background

Adverse drug events that lead to emergency department visits are a significant cause of morbidity in the United States, particularly among individuals aged 65 years or older. It is reported that for every dollar spent on pharmaceuticals, another dollar is spent to manage drug-related problems (Ernst and Grizzle, 2001). Continuous population-based surveillance could be an effective method for monitoring these events and targeting prevention strategies (Budnitz, et al, 2006).

A study conducted by the Institute for Safe Medication Practices and reported in the Archives of Internal Medicine, indicated that the number of serious and fatal adverse drug events reported to the U.S. Food and Drug Administration more than doubled between 1998 and 2005 (Moore et al, 2007). With a growing elderly population, the use of persistent medication is also likely to grow, thereby increasing the need for therapeutic drug monitoring.

Measure Definition

The *Annual Monitoring for Patients on Persistent Medications* measure shows the percentage of members 18 years of age and older who receive at least a 180 day supply of ambulatory medication therapy for a select therapeutic agent, and at least one therapeutic monitoring event. For each product line, rates of the following drugs are reported:

- ACE/ARBs
- Digoxins
- Diuretics
- Anticonvulsants

The measure produces a combined rate and separate rates for each drug.

Data Collection Methodology

This measure is collected using the Administrative Method.

Summary of Changes to HEDIS 2008

Changes made to this measure in 2008 include the deletion of the ACE inhibitors and ARBs table; the optional exclusion for identifying inpatient admissions refers organizations to a more comprehensive code table to identify non-acute inpatient encounters; and the deletion of total exclusions data element from Table MPM-1/2/3.

HMO/POS Results *(see Table 53)*

- In 2008, HMO/POS plan rates ranged from 75–81 percent. Plans either performed significantly above the Maryland average of 78 percent or significantly below it.
- Three plans went from below average scores in 2007 to above average scores in 2008.

Table 53: Annual Monitoring for Patients on Persistent Medications

	Comparison of Absolute Rates		Comparison of Relative Rates	
	2007	**2008**	**2007**	**2008**
Maryland HMO/POS Average	**81%**	**78%**		
Aetna	78%	79%	★	★★★
BlueChoice	77%	81%	★	★★★
CIGNA	71%	80%	★	★★★
Coventry	74%	75%	★	★
Kaiser Permanente	74%	75%	★	★
M.D. IPA	98%	79%	★★★	★★★
OCI	97%	77%	★★★	★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

ACCESS/AVAILABILITY OF CARE

ACCESS/AVAILABILITY OF CARE

Overview

This section presents results for the measures in HEDIS 2008 *Access/Availability of Care* domain that MHCC required Maryland commercial HMO/POS plans to report in 2008. PPOs did not report on any measures in this domain. The listed measures are designed to approximate the level of access that members have to their health care delivery systems.

Measures in Domain

- Adolescent Well-Care Visits
- Prenatal and Postpartum Care
- Well-Child Visits for Infants and Children (Composite)
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Measures Eligible for Rotation in HEDIS 2008

- Prenatal and Postpartum Care

Plans that rotated this measure are identified by the superscript "r" (^{r}) in the results tables.

Well-Child and Adolescent Well-Care Visit Measures

These measures report information on several subsets of members who were continuously enrolled in the health plan for a specified period of time and received routine care.

Prenatal and Postpartum Care

This measure includes timely initiation of prenatal care and check-ups after delivery.

WELL-CHILD AND ADOLESCENT VISIT MEASURES

Background

Well-care visits provide health professionals with the opportunity to give patients information about medical conditions, safety, nutrition, physical activity, and behavioral health. Anticipatory guidance, screening, and counseling to improve health status should be predominant in pediatric and adolescent preventive care (Committee on Adolescence, American Academy of Pediatrics, 2008). In its *Guidelines for Adolescent Preventive Services,* the American Medical Association's Department of Adolescent Health recommends that all adolescents have an annual routine health visit (Montalto, 1998).

In 2006, an estimated 90 percent of children under 18 years of age had contact with a health care professional and 95 percent of children had a usual place of health care (CDC, 2008) Nonetheless, limited numbers of adolescents are provided with the recommended comprehensive preventive counseling and screening services on alcohol use, depression, sexual activity, smoking, injury prevention, physical activity, and nutrition (Committee on Adolescence, American Academy of Pediatrics, 2008.

Measure Definition

Well-Child Visits in the First 15 Months of Life: This measure reports the percentage of children who turned 15 months old during 2007 and received *six or more* well-child visits by the time they reached 15 months of age.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life: This measure reports the percentage of children 3–6 years of age in 2007 who received *one or more* well-child visits with a primary care physician during the measurement year.

Well-Child Visits for Infants and Children (Composite): This measure combines rates of well-child visits for infants from birth to 15 months and well-child visits for children 3–6 years to create one composite measure. Criteria remain the same as in the individual measures.

Data Collection Methodology

These measures are collected using either the Administrative Method or the Hybrid Method.

Summary of Changes to HEDIS 2008

There are no significant changes to these measures.

Notes

- These measures are similar to the *Effectiveness of Care* measures in that higher rates indicate better performance. Trending and relative performance information is presented for these measures.

HMO/POS Results

Well-Child Visits in the First 15 Months of Life (See Table 54)

- In 2008, most HMO/POS plans significantly increased their rates of well-child visits within the first 15 months of life. Only two plans did not experience significant change.
- Plans rates ranged from 64–85 percent; the Maryland HMO/POS average was 79 percent.
- Three plans received above-average scores, while two received average scores, and two received below-average scores.

Table 54: Well-Child Visits in the First 15 Months of Life, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**72%**	**78%**	**79%**	**7%**			
Aetna[m]	62%	69%	64%	⇔	★	★	★
BlueChoice[m]	74%	77%	77%	↑	★★★	★★	★
CIGNA[m]	80%	82%	82%	↑	★★★	★★★	★★★
Coventry[m]	81%	82%	80%	⇔	★★★	★★★	★★
Kaiser Permanente[m]	63%	78%	81%	↑	★	★★	★★★
M.D. IPA	76%	76%	85%	↑	★★★	★★	★★★
OCI	71%	80%	81%	↑	★	★★	★★

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- [m]This plan used the Administrative Method to calculate this rate.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (See Table 55)

- The Maryland HMO/POS average did not change between 2006 and 2008. During this time, three plans significantly increased their individual rates; three plans did not experience significant change, and one plan significantly decreased its rate.
- In 2008, three plans performed significantly above the Maryland HMO/POS average, three plans received average scores, and one plan received below-average scores.

Table 55: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**73%**	**74%**	**73%**	**0%**			
Aetna[m]	72%	76%	75%	↑	★★	★★	★★★
BlueChoice[m]	72%	74%	75%	↑	★★	★★	★★★
CIGNA[m]	70%	72%	74%	↑	★	★	★★★
Coventry[m]	73%	74%	73%	⇔	★★	★★	★★
Kaiser Permanente[m]	69%	70%	68%	⇔	★	★	★
M.D. IPA	79%	79%	72%	↓	★★★	★★★	★★
OCI	73%	73%	72%	⇔	★★	★★	★★

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- [m]This plan used the Administrative Method to calculate this rate.

Well-Child Visits for Infants and Children (Composite) (See Table 56)

- From 2006–2008, the Maryland HMO/POS average increased by 3 percentage points to 76 percent. One plan showed a 9 percentage point increase, three times the average increase across Maryland HMO/POS plans. Despite this significant increase in performance, the plan scored below the Maryland average.
- Five of seven plans showed significant increases and two plans did not show any significant change.

Table 56: Well-Child Visits for Infants and Children (Composite), Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**72%**	**76%**	**76%**	**4%**			
Aetna[m]	67%	73%	69%	↑	★	★	★
BlueChoice[m]	73%	75%	76%	↑	★★★	★★	★★
CIGNA[m]	75%	77%	78%	↑	★★★	★★★	★★★
Coventry[m]	77%	78%	76%	⇔	★★★	★★★	★★
Kaiser Permanente[m]	66%	74%	75%	↑	★	★	★
M.D. IPA	77%	77%	79%	⇔	★★★	★★★	★★★
OCI	72%	77%	76%	↑	★★	★★★	★★

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- [m]This plan used the Administrative Method to calculate this rate.

Adolescent Well-Care Visits (See Table 57)

- Between 2006 and 2008, the Maryland HMO/POS average for adolescent well-care visits increased by 5 percentage points. While all plans significantly increased their rates during this period, no plan performed above the Maryland HMO/POS average of 44 percent.

Table 57: Adolescent Well-Care Visits, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**39%**	**45%**	**44%**	**5%**			
Aetna[m]	39%	48%	43%	↑	★★★	★★	★
BlueChoice[m]	42%	46%	45%	↑	★★★	★★	★★
CIGNA[m]	37%	42%	44%	↑	★	★	★★
Coventry[m]	40%	42%	44%	↑	★★★	★	★★
Kaiser Permanente[m]	37%	41%	42%	↑	★	★	★
M.D. IPA	38%	45%	45%	↑	★	★★	★★
OCI	38%	49%	48%	↑	★	★★★	★★

Table 58: Well-Child and Adolescent Visits, 2008 Results

Maryland HMO/POS Average	Well-Child in 1st 15 Months		Well-Child in 3rd, 4th, 5th, 6th Years		Well-Child for Infants and Children (Comp)		Adolescent Well-Care	
	79%		73%		76%		44%	
Aetna[m]	64%	★	75%	★★★	69%	★	43%	★
BlueChoice[m]	77%	★	75%	★★★	76%	★★	45%	★★
CIGNA[m]	82%	★★★	74%	★★★	78%	★★★	44%	★★
Coventry[m]	80%	★★	73%	★★	76%	★★	44%	★★
Kaiser Permanente[m]	81%	★★★	68%	★	75%	★	42%	★
M.D. IPA	85%	★★★	72%	★★	79%	★★★	45%	★★
OCI	81%	★★	72%	★★	76%	★★	48%	★★

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- [m]This plan used the Administrative Method to calculate this rate.

PRENATAL AND POSTPARTUM CARE

Background

Every day, one to two women die of pregnancy-related complications in the United States (CDC, 2008). Even though maternal mortality is the most severe outcome, a much greater number of pregnant women are affected by related complications, including hemorrhage, ectopic (tubal) pregnancy, pregnancy-induced hypertension, infection, and depression (CDC, 2008).

Preventable maternal death rates have decreased with improvement in antibiotics, obstetric procedures, and infection control (CDC, 2008), though studies indicate close to half the deaths due to pregnancy complications could be prevented if women had better access to quality health care and practiced healthy behaviors.

Infant survival greatly depends on the mother's prenatal care, which affects birth weight and gestation period. In 2005, the overall national infant mortality rate was 6.86 infant deaths per 1,000 live births, slightly higher than the 2004 rate of 6.78 per 1,000 births. Two-thirds (18,782) of all infant deaths took place during the neonatal period (birth–27 days old). Among 37 reporting states, the mortality rate among infants born to mothers who had prenatal care after the first trimester of pregnancy or no prenatal care at all was 8.69 per 1,000 live births, compared to 6.2 per 1,000 live births for infants with mothers who began prenatal care in the first trimester. (Mathews and MacDorman, 2008)

In Maryland, the infant mortality rate continues to be much higher than the national average. According to the Maryland Department of Health and Mental Hygiene, the rate at which Maryland newborns die before their first birthday is among the highest in the nation. Despite the fact that Maryland is one of the wealthiest states in the country, in 2007 the infant mortality rate was 8 deaths per 1,000 births. In select Maryland counties, the infant mortality rate is much higher than the state average. Baltimore and Prince Georges County reported rates slightly above 11 deaths per 1,000 births, while Dorchester County reported a rate of 17 deaths per 1,000 births in 2007. Somerset County's infant mortality rate is three times the state average, at 24 deaths per 1,000 births. The rate for African American infant deaths is nearly three times that of white infants.

Measure Definition

The *Prenatal and Postpartum Care* measure includes two rates based on the population of commercially-insured women who delivered a live baby between November 6, 2006, and November 5, 2007, and who were continuously enrolled at least 43 days prior to delivery through 56 days after delivery. For this population, the measure calculates the following.

Prenatal Care (Timeliness of Prenatal Care)

The percentage of women who received a prenatal care visit in the first trimester or within 42 days of enrollment in the health plan.

Postpartum Care

The percentage of women who had a postpartum visit on or between 21 and 56 days after delivery.

Data Collection Methodology

This measure can be collected using either the Administrative Method or the Hybrid Method. All Maryland plans used the Hybrid Method. This measure was eligible for rotation in HEDIS 2008.

Summary of Changes to HEDIS 2008

Coding changes made to the measure do not affect comparability to prior years' measures.

Notes

Several factors can complicate calculating *Prenatal and Postpartum Care* results. Readers should consider the following when interpreting results.

- Demographic, socioeconomic, and cultural factors affect the likelihood of women seeking early prenatal care. Demographic and economic profiles of members may be very different across health plans.
- Poor quality coding of maternity data, commonly found throughout the industry, can complicate accurate measurement by creating difficulty in identifying the true number of live births.
- The majority of HMOs use global billing practices. HMOs pay providers a fixed rate for all maternity services, from prenatal to postpartum care, including delivery. This payment arrangement can make it difficult to identify the number and dates of prenatal care visits.

HMO/POS Results

Prenatal Care (See Table 59)

- Neither the Maryland HMO/POS average nor health plans' averages experienced significant changes in rates between 2006 and 2008.
- In 2008, plan rates ranged from 87-98 percent, with a Maryland average of 93 percent.
- Two plans received scores above the Maryland average, while four plans received average scores, and one plan received a score below average.

Table 59: Prenatal Care, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**93%**	**92%**	**93%**	**0%**			
Aetna[r]	95%	96%	96%	⇔	★★★	★★★	★★★
BlueChoice[r]	96%	94%	94%	⇔	★★★	★★	★★
CIGNA[r]	98%	98%	98%	⇔	★★★	★★★	★★★
Coventry[r]	92%	92%	92%	⇔	★★	★★	★★
Kaiser Permanente[r]	94%	94%	94%	⇔	★★	★★	★★
M.D. IPA[r]	88%	87%	87%	⇔	★	★	★
OCI	87%	82%	91%	⇔	★	★	★★

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- [r]This measure was eligible for rotation in 2008 and this plan elected to resubmit 2007 data in 2008.

Postpartum Care (See Table 60)

- The Maryland HMO/POS average for postpartum care decreased 5 percentage points between 2006 and 2008. Five plans saw no significant change in rate during this period, while two plans significantly decreased their rates by 10 and 7 percentage points.
- HMO/POS plan rates ranged from 70–90 percent, with a Maryland average of 80 percent. Two plans received scores above the Maryland average while three plans received average scores and two received below-average scores.

Table 60: Postpartum Care, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**83%**	**78%**	**80%**	**-5%**			
Aetna[r]	82%	79%	79%	⇔	★★	★★	★★
BlueChoice[r]	82%	87%	87%	⇔	★★	★★★	★★★
CIGNA[r]	88%	90%	90%	⇔	★★★	★★★	★★★
Coventry[r]	82%	78%	78%	⇔	★★	★★	★★
Kaiser Permanente[r]	87%	84%	84%	⇔	★★★	★★★	★★
M.D. IPA[r]	80%	70%	70%	🡻	★★	★	★
OCI	78%	61%	71%	🡻	★	★	★

Legend

Change 2006–2008

🡹 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡻 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- [r]This measure was eligible for rotation in 2007 and this plan elected to resubmit 2007 data in 2008.

SATISFACTION WITH THE EXPERIENCE OF CARE

SATISFACTION WITH THE EXPERIENCE OF CARE

Overview

This section presents selected results from the CAHPS 4.0H survey. Responses represent the opinions of a sample of managed care members drawn from seven HMO/POS plans and four PPO plans. Kaiser POS members were not included in either the survey or the audit; responses for this plan represent HMO members only. For consumers making enrollment decisions, knowledge of member satisfaction with a health plan is valuable information. Member surveys collect satisfaction statistics that can provide consumers with a different point of view from that of family, friends, and colleagues. Survey results give potential members the opportunity to assess how well current members believe their plan meets their needs.

MHCC contracted with Weidner Burrows & Associates Market Research (WB&A) to conduct the CAHPS 4.0H survey. As an NCQA-Certified survey vendor, WB&A administered the survey according to protocols established by NCQA. A random sample of 1,210 members from each health plan was contacted for participation in the mail survey, with phone follow-up for nonrespondents. The survey samples consisted of current health plan members 18 years of age and older who were enrolled in the health plan throughout 2007. Survey data collection began in February 2008 and ended in April 2008. See Appendix D for more information.

Results are based on either a single survey question or on a composite of several questions. Composite measures group several questions that rate similar aspects of health care or health plan services and have the same response options (for example, questions forming a single composite measure result all have the same response options, such as *Sometimes/Never/Usually/Always*).

Measures Reported in This Domain:

- Coordination of Care†
- Getting Care Quickly†
- Getting Needed Care†
- Health Plan Customer Service†
- Health Promotion and Education†
- How Well Doctors Communicate†
- Rating of Health Care†
- Rating of Health Plan†
- Shared Decision Making†

†*Comparative data provided for HMO/POS and PPO health plans*

Summary of CAHPS 4.0H Changes

Changes to the survey include the removal of a Customer Service composite question; however, it is still included in the survey questionnaire. Health plans are not required to request permission to oversample using rates >30 percent; and the process and requirements for supplemental questions have been revised. In 2008, the specifications for all products are part of a single publication, *HEDIS Volume 3: Specifications for Survey Measures*. PPO specifications have been updated to align with HMO and POS product requirements.

Overall CAHPS 4.0H Survey Results

Table 61: Satisfaction With the Experience of Care, 2008 HMO/POS Results

	Rating of HP[a]	HP Customer Service[b]	Getting Needed Care[b]	Getting Care Quickly[b]	How Well Drs. Com-municate[b]	Rating of Health Care[c]	Shared Decision Making[b]	Health Promotion and Ed.[b]	Coordina-tion of Care[b]
Maryland HMO/POS Average	**33%**	**51%**	**45%**	**51%**	**65%**	**39%**	**56%**	**25%**	**41%**
Aetna	25%	54%	43%	49%	65%	40%	55%	26%	37%
BlueChoice	36%	41%	46%	50%	66%	43%	53%	24%	42%
CIGNA	38%	52%	45%	57%	64%	40%	55%	27%	38%
Coventry	30%	54%	52%	54%	69%	45%	60%	26%	48%
Kaiser Permanente	33%	45%	41%	45%	63%	36%	54%	24%	42%
M.D. IPA	34%	55%	43%	49%	65%	38%	55%	22%	39%
OCI	33%	52%	45%	52%	62%	33%	60%	27%	43%

Table 62: Satisfaction With the Experience of Care, 2008 PPO Results

	Rating of HP[a]	HP Customer Service[b]	Getting Needed Care[b]	Getting Care Quickly[b]	How Well Drs. Com-municate[b]	Rating of Health Care[c]	Shared Decision Making[b]	Health Promotion and Ed.[b]	Coordina-tion of Care[b]
Maryland PPO Average	**36%**	**52%**	**45%**	**56%**	**66%**	**41%**	**55%**	**26%**	**40%**
Aetna PPO	29%	47%	46%	52%	64%	36%	52%	26%	36%
BluePreferred	48%	55%	48%	61%	70%	46%	56%	31%	44%
CGLIC	29%	49%	41%	49%	60%	35%	47%	21%	36%
MAMSI Life	38%	59%	47%	61%	70%	46%	64%	27%	44%

Notes

a. Results are based on the percentage of members surveyed who gave their health plan a rating of 9 or 10 on a scale of 0–10, with 10 being the "best health plan possible."
b. Results are based on the percentage of members surveyed who responded "Always" to several related questions.
c. Results are based on the percentage of members surveyed who gave the health care they received a rating of 9 or 10 on a scale of 0–10, with 10 being the "Best health care possible."

RATING OF HEALTH PLAN

Measure Definition

The *Rating of Health Plan* measure asked the following question.

"Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"

HMO/POS Results *(see Tables 63–64)*

Rate comparisons are based on the percentage of surveyed members who gave their health plan a rating of 9 or 10 on a scale of 0–10, with 10 being the "best health plan possible."

- From 2006–2008, the percent of Maryland HMO/POS members who rated their plan a 9 or 10 decreased by 5 percentage points. Four plans' rates significantly decreased and one plan's rate significantly increased from 2006–2008.
- In 2008, on average, 33 percent of members gave their health plan a rating of 9 or 10. Across the seven plans, rates ranged from 25–38 percent. One plan received an above-average score and one plan received a below-average score compared with the Maryland average.
- On average, 45 percent of the surveyed members gave their health plan a rating of 7 or 8, while 23 percent of members rated their plan 0-6.

Table 63: Rating of Health Plan, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**38%**	**34%**	**33%**	**-5%**			
Aetna	36%	31%	25%	🡻	★★	★★	★
BlueChoice	43%	37%	36%	🡻	★★★	★★	★★
CIGNA	31%	33%	38%	🡹	★	★★	★★★
Coventry	39%	34%	30%	🡻	★★	★★	★★
Kaiser Permanente	37%	36%	33%	⇔	★★	★★	★★
M.D. IPA	39%	38%	34%	⇔	★★	★★	★★
OCI	41%	32%	33%	🡻	★★	★★	★★

Table 64: Rating of Health Plan, 2008 Results All Response Options

	Rating 0–6	Rating 7–8	Rating 9–10
Maryland HMO/POS Average	**23%**	**45%**	**33%**
Aetna	23%	52%	25%
BlueChoice	21%	44%	36%
CIGNA	21%	41%	38%
Coventry	28%	42%	30%
Kaiser Permanente	20%	47%	33%
M.D. IPA	23%	43%	34%
OCI	23%	44%	33%

Legend

Change 2006–2008

🡹 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡻 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- Numbers may not add to 100% due to rounding.

PPO Results *(see Tables 65–66)*

Rate comparisons are based on the percentage of surveyed members who gave their health plan a rating of 9 or 10 on a scale of 0–10, with 10 being the "best health plan possible."

- In 2008, an average of 36 percent of Maryland PPO members gave their health plan a rating of 9 or 10. Across the four plans, rates ranged from 29–48 percent. Two plans received below-average scores, while one plan received an above-average score compared with the Maryland average.
- On average, 41 percent of surveyed members gave their health plan a rating of 7 or 8, while 23 percent of members rated their plan 0–6.

Table 65: Rating of Health Plan, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**36%**	
Aetna PPO	29%	★
BluePreferred	48%	★★★
CGLIC	29%	★
MAMSI Life	38%	★★

Table 66: Rating of Health Plan, 2008 Results All Response Options

	Rating 0–6	Rating 7–8	Rating 9–10
Maryland PPO Average	**23%**	**41%**	**36%**
Aetna PPO	27%	44%	29%
BluePreferred	12%	40%	48%
CGLIC	30%	41%	29%
MAMSI Life	24%	37%	38%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.
- Numbers may not add to 100% due to rounding.

HEALTH PLAN CUSTOMER SERVICE

Measure Definition

The *Health Plan Customer Service* measure is a composite of the following survey questions.

- *"In the last 12 months, how often did your health plan's customer service give you the information or help you needed?"*
  - Only respondents who called their health plan's Customer Service Department for information or help in the last 12 months were asked this question.
- *"In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?"*
  - Only respondents who called their health plan's Customer Service Department for information or help in the last 12 months were asked this question.
- *"In the last 12 months, did your health plan give you any forms to fill out,"* ***or*** *"In the last 12 months, how often were the forms from your health plan easy to fill out?"*
  - Respondents who had no experience with paperwork for their health plan in the last 12 months were considered to have never had a problem filling out paperwork.

HMO/POS Results *(see Tables 67–68)*

Rate comparisons are based on the percentage of surveyed members who responded "Always" to the preceding questions.

- In 2008, an average of 51 percent of Maryland members reported their health plans' Customer Service Department always gave them the information or help that was needed; the health plans' Customer Service staff treated them with courtesy and respect; and forms were always easy to fill out. Rates ranged from 41–55 percent across seven plans, with two plans receiving below-average scores and one plan receiving an above average-score compared with the Maryland average.
- On average, 29 percent of the surveyed members said their health plan usually provided them with appropriate customer service, while 20 percent reported their health plan sometimes or never provided them with appropriate service.

Table 67: Health Plan Customer Service Results

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**70%**	**56%**	**51%**			
Aetna	70%	51%	54%	★★	★	★★
BlueChoice	68%	56%	41%	★★	★★	★
CIGNA	65%	54%	52%	★	★★	★★
Coventry	69%	58%	54%	★★	★★	★★
Kaiser Permanente	70%	55%	45%	★★	★★	★
M.D. IPA	77%	64%	55%	★★★	★★★	★★★
OCI	71%	55%	52%	★★	★★	★★

Table 68: Health Plan Customer Service, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland HMO/POS Average	**20%**	**29%**	**51%**
Aetna	16%	30%	54%
BlueChoice	29%	30%	41%
CIGNA	18%	29%	52%
Coventry	21%	25%	54%
Kaiser Permanente	23%	32%	45%
M.D. IPA	18%	27%	55%
OCI	16%	32%	52%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- Respondents who had no experience with paperwork automatically scored "Always" to the question, "In the last 12 months, how often were the forms from your health plan easy to fill out?"
- Because of changes to the wording of this question in the CAHPS survey in 2007, results for this measure cannot be trended to 2006 results.
- Numbers may not add to 100% due to rounding.

PPO Results *(see Tables 69–70)*

Rate comparisons are based on the percentage of surveyed members who responded "Always" to the preceding questions.

- In 2008, an average of 52 percent of Maryland PPO members reported their health plans' Customer Service Department always gave them the information or help they needed, treated them with courtesy and respect, and the forms were always easy to fill out. Rates ranged from 47–59 percent across the four plans. One plan received a below-average score and one plan received an above-average score compared with the Maryland average.
- On average, 28 percent of the surveyed PPO members said they usually received appropriate customer service, while 20 percent reported they sometimes or never did.

Table 69: Health Plan Customer Service, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**52%**	
Aetna PPO	47%	★
BluePreferred	55%	★★
CGLIC	49%	★★
MAMSI Life	59%	★★★

Table 70: Health Plan Customer Service, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland PPO Average	**20%**	**28%**	**52%**
Aetna PPO	23%	30%	47%
BluePreferred	17%	28%	55%
CGLIC	22%	30%	49%
MAMSI Life	18%	24%	59%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- Respondents who had no experience with paperwork automatically scored "Always" to the question, "In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?"
- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.
- Numbers may not add to 100% due to rounding.

GETTING NEEDED CARE

Measure Definition

The *Getting Needed Care* measure is a composite of the following survey questions.

- *"In the last 12 months, how often was it easy to get appointments with specialists?"*
  - Only respondents who needed to see a specialist in the last 12 months were asked this question.
- *"In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?"*
  - Only respondents who thought they needed care, tests, or treatment in the last 12 months were asked this question.

HMO/POS Results *(see Tables 71–72)*

Rate comparisons are based on the percentage of surveyed members who responded "Always" to the preceding questions.

- In 2008, an average of 45 percent of Maryland HMO/POS members reported it was always easy to get needed care. Rates ranged from 41–52 percent across seven plans, with one plan receiving an above-average score compared with the Maryland average.
- On average, 36 percent of the surveyed members said they usually received needed care through their health plans, while 19 percent reported it was sometimes or never easy to get needed care.

Table 71: Getting Needed Care Results

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**76%**	**46%**	**45%**			
Aetna	74%	42%	43%	★★	★★	★★
BlueChoice	77%	47%	46%	★★	★★	★★
CIGNA	77%	48%	45%	★★	★★	★★
Coventry	79%	54%	52%	★★	★★★	★★★
Kaiser Permanente	71%	41%	41%	★	★	★★
M.D. IPA	75%	46%	43%	★★	★★	★★
OCI	79%	44%	45%	★★★	★★	★★

Table 72: Getting Needed Care, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland HMO/POS Average	**19%**	**36%**	**45%**
Aetna	20%	38%	43%
BlueChoice	20%	35%	46%
CIGNA	19%	36%	45%
Coventry	16%	32%	52%
Kaiser Permanente	26%	34%	41%
M.D. IPA	20%	37%	43%
OCI	17%	38%	45%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- Because of changes to the wording of this question in the CAHPS survey in 2007, results for this measure cannot be trended to 2006 results.
- Respondents who did not require approval for care, tests, or treatment were automatically scored "Always" for the question, "In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?"
- Numbers may not add to 100% due to rounding.

PPO Results *(see Tables 73–74)*

Rate comparisons are based on the percentage of surveyed members who responded "Always" to the preceding questions.

- In 2008, an average of 45 percent of Maryland PPO members reported they always received necessary care. Rates ranged from 41-48 percent across the four plans. All plans received average rates compared with the Maryland average.
- On average, 38 percent of the surveyed PPO members said they usually received needed care, while 17 percent reported they sometimes or never got needed care.

Table 73: Getting Needed Care, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**45%**	
Aetna PPO	46%	★★
BluePreferred	48%	★★
CGLIC	41%	★★
MAMSI Life	47%	★★

Table 74: Getting Needed Care, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland PPO Average	**17%**	**38%**	**45%**
Aetna PPO	17%	37%	46%
BluePreferred	14%	38%	48%
CGLIC	19%	40%	41%
MAMSI Life	18%	36%	47%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.
- Numbers may not add to 100% due to rounding.

GETTING CARE QUICKLY

Measure Definition

The *Getting Care Quickly* measure is a composite of the following survey questions.

- *"In the last 12 months, when you needed care right away how often did you get care as soon as you thought you needed?"*
  - Only respondents who thought they needed care right away in the last 12 months were asked this question.
- *"In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?"*
  - Only respondents who made an appointment for health care they did not need right away in the last 12 months were asked this question.)

HMO/POS Results *(see Tables 75–76)*

Rate comparisons are based on the percentage of surveyed members who responded "Always" to the preceding questions.

- In 2008, 51 percent of Maryland HMO/POS plan members responded they always received care quickly. Rates for this measure ranged from 45–57 percent, with one plan receiving an above-average score and one plan receiving a below-average score, compared with the Maryland average.
- Of the members surveyed, 18 percent reported they were sometimes or never able to get care quickly.

Table 75: Getting Care Quickly, Results

	Comparison of Absolute Rates			Comparison of Relative Rates		
	2006	2007	2008	2006	2007	2008
Maryland HMO/POS Average	**41%**	**56%**	**51%**			
Aetna	40%	58%	49%	★★	★★	★★
BlueChoice	44%	56%	50%	★★	★★	★★
CIGNA	41%	57%	57%	★★	★★	★★★
Coventry	48%	65%	54%	★★★	★★★	★★
Kaiser Permanente	37%	48%	45%	★	★	★
M.D. IPA	38%	55%	49%	★★	★★	★★
OCI	41%	55%	52%	★★	★★	★★

Table 76: Getting Care Quickly, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland HMO/POS Average	**18%**	**31%**	**51%**
Aetna	18%	33%	49%
BlueChoice	16%	34%	50%
CIGNA	13%	30%	57%
Coventry	14%	32%	54%
Kaiser Permanente	24%	30%	45%
M.D. IPA	18%	33%	49%
OCI	21%	27%	52%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- Because of changes to the wording of this question in the CAHPS survey in 2007, results for this measure cannot be trended to 2006 results.
- Numbers may not add to 100% due to rounding.

PPO Results *(see Table 77–78)*

Rate comparisons are based on the percentage of surveyed members who responded "Always" to the preceding questions.

- In 2008, 56 percent of Maryland PPO plan members reported that they always received care quickly. Rates for this measure ranged from 49–61 percent across the four plans, with two plans receiving an above-average score and one plan receiving a below-average score, compared with the Maryland average.
- Of the members surveyed, 15 percent reported that they were sometimes or never able to get care quickly.

Table 77: Getting Care Quickly, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**56%**	
Aetna PPO	52%	★★
BluePreferred	61%	★★★
CGLIC	49%	★
MAMSI Life	61%	★★★

Table 78: Getting Care Quickly, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland PPO Average	**15%**	**29%**	**56%**
Aetna PPO	18%	31%	52%
BluePreferred	12%	27%	61%
CGLIC	22%	29%	49%
MAMSI Life	10%	29%	61%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.
- Numbers may not add to 100% due to rounding.

HOW WELL DOCTORS COMMUNICATE

Measure Definition

The *How Well Doctors Communicate* measure is a composite of several questions. Only respondents who had been to a doctor's office or clinic to get care for themselves in the last 12 months were asked the following survey questions.

- *"In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?"*
- *"In the last 12 months, how often did your personal doctor listen carefully to you?"*
- *"In the last 12 months, how often did your personal doctor show respect for what you had to say?"*
- *"In the last 12 months, how often did your personal doctor spend enough time with you?"*

HMO/POS Results *(see Tables 79–80)*

Rate comparisons are based on the percentage of surveyed members who responded "Always" to the preceding questions.

- From 2006–2008, the percentage of Maryland HMO/POS members who responded "Always" increased by six percentage points to 65 percent. Three of seven plans showed a significant increase in their rates.
- In 2008, plan rates ranged from 62–69 percent, with all plans receiving average scores compared with the Maryland average.
- Nine percent of respondents expressed dissatisfaction with how well their doctors communicated.

Table 79: How Well Doctors Communicate, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**59%**	**69%**	**65%**	**6%**			
Aetna	61%	68%	65%	⇔	★★	★★	★★
BlueChoice	62%	67%	66%	⇔	★★	★★	★★
CIGNA	59%	65%	64%	⇔	★★	★★	★★
Coventry	61%	77%	69%	↑	★★	★★★	★★
Kaiser Permanente	55%	69%	63%	↑	★	★★	★★
M.D. IPA	55%	67%	65%	↑	★	★★	★★
OCI	60%	68%	62%	⇔	★★	★★	★★

Table 80: How Well Doctors Communicate, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland HMO/POS Average	**9%**	**26%**	**65%**
Aetna	9%	26%	65%
BlueChoice	9%	24%	66%
CIGNA	9%	26%	64%
Coventry	8%	23%	69%
Kaiser Permanente	11%	25%	63%
M.D. IPA	9%	26%	65%
OCI	10%	28%	62%

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- Because of changes to the wording of this question in the CAHPS survey in 2007, trending performance over time should be pursued with caution.
- Numbers may not add to 100% due to rounding.

PPO Results *(see Tables 81–82)*

Rate comparisons are based on the percentage of surveyed members who responded "Always" to the preceding questions.

- In 2008, 66 percent of Maryland PPO plan members reported that that their doctors were effective communicators.
- In 2008, PPO plan rates ranged from 60-70 percent, with one plan receiving a below-average score, compared with the Maryland average.
- In 2008, 8 percent of respondents expressed dissatisfaction with how well their doctors communicated.

Table 81: How Well Doctors Communicate, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**66%**	
Aetna PPO	64%	★★
BluePreferred	70%	★★
CGLIC	60%	★
MAMSI Life	70%	★★

Table 82: How Well Doctors Communicate, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland PPO Average	**8%**	**26%**	**66%**
Aetna PPO	10%	26%	64%
BluePreferred	5%	25%	70%
CGLIC	10%	30%	60%
MAMSI Life	7%	22%	70%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.
- Numbers may not add to 100% due to rounding.

RATING OF HEALTH CARE

Measure Definition

The *Rating of Health Care* measure asked the following question.

- *"Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?"*

HMO/POS Results *(see Tables 83–84)*

Rate comparisons are based on the percentage of surveyed members who gave their health care a rating of 9 or 10 on a scale of 0–10, with 10 being the "best health care possible."

- From 2006–2008, the percentage of Maryland HMO/POS members who rated their health care 9 or 10 decreased by eight percentage points. Three of seven plans' ratings decreased significantly.
- In 2008, rates ranged from 33–45 percent, with one plan receiving an above-average score compared with the Maryland average.
- Around 44 percent of members gave their health care a rating of 7 or 8, while only 16 percent rated their health care 0–6.

Table 83: Rating of Health care, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**47%**	**43%**	**39%**	**-8%**			
Aetna	47%	44%	40%	⇔	★★	★★	★★
BlueChoice	53%	46%	43%	🡻	★★★	★★	★★
CIGNA	44%	40%	40%	⇔	★★	★★	★★
Coventry	51%	52%	45%	⇔	★★	★★★	★★★
Kaiser Permanente	41%	38%	36%	⇔	★	★	★★
M.D. IPA	45%	44%	38%	🡻	★★	★★	★★
OCI	49%	40%	33%	🡻	★★	★★	★★

Table 84: Rating of Health Care, 2008 Results All Response Options

	Rating 0–6	Rating 7–8	Rating 9–10
Maryland HMO/POS Average	**16%**	**44%**	**39%**
Aetna	16%	44%	40%
BlueChoice	16%	42%	43%
CIGNA	13%	47%	40%
Coventry	12%	42%	45%
Kaiser Permanente	19%	45%	36%
M.D. IPA	18%	44%	38%
OCI	20%	47%	33%

Legend

Change 2006–2008

🡹 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡻 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- Because of changes to the wording of this question in the CAHPS survey in 2007, trending performance over time should be pursued with caution.
- Numbers may not add to 100% due to rounding.

PPO Results *(see Tables 85–86)*

Rate comparisons are based on the percentage of surveyed members who gave their health care a rating of 9 or 10 on a scale of 0–10, with 10 being the "best health care possible."

- In 2008, an average of 41 percent of Maryland PPO members rated their health care 9 or 10.
- PPO rates ranged from 35–46 percent, with two plans receiving above-average ratings and two plans receiving below-average ratings compared with the Maryland average.
- Around 45 percent of PPO members gave their health care a rating of 7 or 8; 14 percent rated their health care 0–6.

Table 85: Rating of Health Care, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**41%**	
Aetna PPO	36%	★
BluePreferred	46%	★★★
CGLIC	35%	★
MAMSI Life	46%	★★★

Table 86: Trending of Health Care, 2008 Results All Response Options

	Rating 0–6	Rating 7–8	Rating 9–10
Maryland PPO Average	**14%**	**45%**	**41%**
Aetna PPO	18%	46%	36%
BluePreferred	10%	44%	46%
CGLIC	16%	48%	35%
MAMSI Life	10%	44%	46%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.
- Numbers may not add to 100% due to rounding.

SHARED DECISION MAKING

Measure Definition

The *Shared Decision Making* measure is a composite of two.

- *"In the last 12 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?"*
- *"In the last 12 months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice was best for you?"*

HMO/POS Results *(see Tables 87-88)*

Rates are based on the percentage of surveyed members who gave their health care a rating of "definitely yes."

- In 2008, on average, 56 percent of HMO/POS Maryland plan members responded "definitely yes" to the preceding questions.
- Plan response rates ranged from 53–60 percent, with all plans receiving average scores compared with the Maryland average.

Table 87: Shared Decision Making

	Comparison of Absolute Rates		Comparison of Relative Rates	
	2007	2008	2007	2008
Maryland HMO/POS Average	**59%**	**56%**		
Aetna	64%	55%	★★	★★
BlueChoice	57%	53%	★★	★★
CIGNA	63%	55%	★★	★★
Coventry	65%	60%	★★	★★
Kaiser Permanente	51%	54%	★	★★
M.D. IPA	57%	55%	★★	★★
OCI	55%	60%	★★	★★

Table 88: Shared Decision Making, 2008 Results All Response Options

	Somewhat/Definitely No	Somewhat Yes	Definitely Yes
Maryland HMO/POS Average	**8%**	**36%**	**56%**
Aetna	10%	35%	55%
BlueChoice	7%	40%	53%
CIGNA	6%	39%	55%
Coventry	8%	32%	60%
Kaiser Permanente	9%	37%	54%
M.D. IPA	7%	38%	55%
OCI	8%	32%	60%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- Numbers may not add to 100% due to rounding.
- This measure will retain first-year measure status in HEDIS 2008 due to the use of rolling average methodology.

PPO Results *(see Tables 89-90)*

Rates are based on the percentage of surveyed members who gave their health care a rating of "definitely yes."

- In 2008, on average, 55 percent of Maryland PPO plan members responded "definitely yes" to the preceding questions.
- Plan response rates ranged from 47–64 percent, with one plan receiving a below-average score and one plan receiving an above-average score compared with the Maryland average.

Table 89: Shared Decision Making, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**55%**	
Aetna PPO	52%	★★
BluePreferred	56%	★★
CGLIC	47%	★
MAMSI Life	64%	★★★

Table 90: Shared Decision Making, 2008 Results All Response Options

	Somewhat/Definitely No	Somewhat Yes	Definitely Yes
Maryland PPO Average	**9%**	**36%**	**55%**
Aetna PPO	10%	38%	52%
BluePreferred	8%	36%	56%
CGLIC	9%	43%	47%
MAMSI Life	8%	27%	64%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.
- Numbers may not add to 100% due to rounding.

HEALTH PROMOTION AND EDUCATION

Measure Definition

The *Health Promotion and Education* measure asked the following question.

- *"In the last 12 months, how often did you and a doctor or other health provider talk about specific things you could do to prevent illness?"*

HMO/POS Results *(see Table 91-92)*

Rates are based on the percentage of surveyed members who gave their health care a rating of "always."

- In 2008, on average, 25 percent of Maryland plan members reported always discussing disease prevention methods with their health care provider.
- Plan response rates ranged from 22–27 percent, with all plans receiving average ratings compared with the Maryland average.

Table 91: Health Promotion and Education, 2008 Results

	Comparison of Absolute Rates		Comparison of Relative Rates	
	2007	2008	2007	2008
Maryland HMO/POS Average	**30%**	**25%**		
Aetna	34%	26%	★★	★★
BlueChoice	28%	24%	★★	★★
CIGNA	32%	27%	★★	★★
Coventry	30%	26%	★★	★★
Kaiser Permanente	31%	24%	★★	★★
M.D. IPA	24%	22%	★	★★
OCI	27%	27%	★★	★★

Table 92: Health Promotion and Education, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland HMO/POS Average	**47%**	**28%**	**25%**
Aetna	45%	29%	26%
BlueChoice	50%	26%	24%
CIGNA	47%	27%	27%
Coventry	48%	26%	26%
Kaiser Permanente	47%	29%	24%
M.D. IPA	44%	34%	22%
OCI	50%	24%	27%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- Numbers may not add to 100% due to rounding.

PPO Results *(see Table 93-94)*

Rates are based on the percentage of surveyed members who gave their health care a rating of "Always."

- In 2008, on average, 26 percent of Maryland PPO plan members reported always discussing disease prevention methods with their health care provider.
- PPO plan response rates ranged from 21–31 percent, with one plan receiving an above-average score and one plan receiving a below-average score, compared with the Maryland average.

Table 93: Health Promotion and Education, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**26%**	
Aetna PPO	26%	★★
BluePreferred	31%	★★★
CGLIC	21%	★
MAMSI Life	27%	★★

Table 94: Health Promotion and Education, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland PPO Average	**46%**	**28%**	**26%**
Aetna PPO	44%	29%	26%
BluePreferred	42%	28%	31%
CGLIC	52%	27%	21%
MAMSI Life	45%	27%	27%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.
- Numbers may not add to 100% due to rounding.

COORDINATION OF CARE

Measure Definition

The *Care Coordination* measure asked the following question.

- *"In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?"*

HMO/POS Results *(see Table 95-96)*

Rates are based on the percentage of surveyed members who gave their health care a rating of "Always."

- In 2008, 41 percent of HMO/POS Maryland plan members reported that their personal doctor always seemed informed and up-to-date about the care they received from other doctors or providers.
- Plans' response rates ranged from 37–48 percent, with one plan receiving an above-average rating compared with the Maryland average.

Table 95: Coordination of Care, Results

	Comparison of Absolute Rates		Comparison of Relative Rates	
	2007	2008	2007	2008
Maryland HMO/POS Average	**45%**	**41%**		
Aetna	43%	37%	★★	★★
BlueChoice	48%	42%	★★	★★
CIGNA	35%	38%	★	★★
Coventry	52%	48%	★★	★★★
Kaiser Permanente	53%	42%	★★★	★★
M.D. IPA	42%	39%	★★	★★
OCI	46%	43%	★★	★★

Table 96: Coordination of Care, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland HMO/POS Average	**26%**	**33%**	**41%**
Aetna	24%	39%	37%
BlueChoice	29%	29%	42%
CIGNA	30%	32%	38%
Coventry	23%	29%	48%
Kaiser Permanente	24%	34%	42%
M.D. IPA	24%	36%	39%
OCI	28%	29%	43%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- Numbers may not add to 100% due to rounding.

PPO Results *(see Table 97-98)*

Rates are based on the percentage of surveyed members who gave their health care a rating of "Always."

- In 2008, 40 percent of Maryland PPO plan members reported that their personal doctor always seemed informed and up-to-date about the care they received from other doctors or providers.
- PPO Plans' response rates ranged from 36–44 percent, with all plans receiving an average rating compared with the Maryland average.

Table 97: Coordination of Care, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**40%**	
Aetna PPO	36%	★★
BluePreferred	44%	★★
CGLIC	36%	★★
MAMSI Life	44%	★★

Table 98: Coordination of Care, 2008 Results All Response Options

	Sometimes/Never	Usually	Always
Maryland PPO Average	**25%**	**35%**	**40%**
Aetna PPO	26%	37%	36%
BluePreferred	26%	30%	44%
CGLIC	27%	37%	36%
MAMSI Life	21%	35%	44%

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.
- Numbers may not add to 100% due to rounding.

BEHAVIORAL HEALTHCARE

BEHAVIORAL HEALTHCARE

Overview

This section contains results of performance indicators related to behavioral healthcare. In addition to collecting behavioral health performance data using the HEDIS measurement tool, HMO, POS, and PPO plans provided information on behavioral health providers serving the same geographic area that the health plan serves.

In a given year, an estimated 26 percent of Americans 18 years of age and older have a diagnosable mental disorder, and 6 percent—or 1 out of 17 Americans—suffer from a serious mental illness, which is characterized as a diagnosable mental disorder that affects work, home, or other social functioning (National Institute of Mental Health, 2008; Substance Abuse and Mental Health Services Administration, n.d.).

In 2007, 9.7 percent of Maryland adults reported frequent mental distress; this is consistent with the 10.1 percent of the nation as a whole. Prevalence of mental distress was highest among 18-to-24-year-olds (CDC, 2007).

The diagnosis and treatment of behavioral health issues is vital to the well-being of individuals with mental disorders and conditions, yet many people do not receive the care they need. In the recent past, inadequate access to services was one of the many issues related to low utilization of behavioral healthcare services. Even when a person had mental health insurance, limitations on maximum number of visits, high copayments and deductibles, and annual and lifetime spending caps restricted coverage and usage (NMHA, 2007).

Managed behavioral health organizations (MBHO) specialize in managing behavioral health services. MBHOs contract with health plans or employers to provide services to the plans' members, though health plans maintain legal responsibility for the quality of care provided by the MBHO.

Utilization data for individuals who received behavioral health services via a separate contract between their employer and an MBHO or through a private arrangement are not included in the results presented here.

Measures Reported by in Domain

- Antidepressant Medication Management: Optimal Practitioner Contacts, Acute and Continuation Treatment Phases†
- Behavioral Healthcare Providers
- Follow-Up After Hospitalization for Mental Illness: 7- day, 30-day†
- Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication: Initiation and Continuation
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Mental Health Utilization—Percentage of Members Receiving Any Services

†*Comparative data provided for HMO/POS and PPO health plans.*

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Background

Symptoms due to mental disorders can lead to hospitalizations. Ensuring the benefits of hospitalization are sustained and the risk of relapse and readmission is minimized, patients should receive follow-up visits with a mental health practitioner shortly after hospital discharge. Contact within seven days can evaluate whether patients have the necessary support to make the transition home. An outpatient visit with a mental health practitioner within 30 days helps patients plan for long term reduction of symptoms.

- In 2005, over seven million outpatient visits in the United States were due to mental disorders (Middleton, Hing & Xu, 2007).
- The number of days between hospital discharge and follow-up appointment is a significant predictor of non-adherence, independent of mental illness type and severity (Compton, Rudisch, Craw, Thompson, & Owens, 2006).
- Studies have suggested that in addition to follow-up appointments, "bridging" interventions such as communication discharge plans with the patient's ambulatory care provider, initiating outpatient programs prior to hospital discharge, educating patients and providing peer support, increase patient engagement in continuing mental health care (Commonwealth Fund, 2006).

Measure Definition

Follow-Up After Hospitalization for Mental Illness details the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

1. 7-Day Measure: The percentage of members who received follow-up within 7 days of discharge.

2. 30-Day Measure: The percentage of members who received follow-up within 30 days of discharge.

Data Collection Methodology

This measure is collected using Administrative Methodology.

Summary of Changes to HEDIS 2008

There are coding changes made to this measure that do not impact comparability to prior year's results.

Notes

Several factors complicate calculating this measure and can lead to underreporting. When interpreting results, readers should consider the following.

- The eligible population for this measure is based on discharges, not on members. The denominator can contain multiple discharges for one individual if discharges occurred more than 30 days apart.
- Since hospitalizations for mental illness do not occur frequently, the number of people who should receive follow-up services is small.
- Mental health services are often not administered by health plan providers because they contracted with external organizations—MBHOs—to provide mental health services. Therefore, they may not always receive complete data from their vendors. Incomplete or missing data will influence a health plan's ability to calculate this measure accurately.

HMO/POS Results *(see Tables 99–100)*

- Comparison of the rates for the two measures showed that, on average, a higher percentage of members received follow-up care within 30 days after being discharged.
- The gap between 7-day and 30-day continuation of care measures has remained consistently wide between 2006 and 2007, suggesting a need for further study on this persistent lag in follow-up care after hospitalization for mental illness.

7-Day Measure (see Table 99)

- In 2008, rates for HMO/POS plans ranged from 46-68 percent, with a Maryland HMO/POS average of 54 percent. Two plans received scores significantly above the Maryland average, two received scores significantly below the Maryland average, and two plans received average scores.
- The Maryland HMO/POS average increased by 2 percentage points between 2006 and 2008. Most plans saw no significant rate change between 2006 and 2008; for two plans, rates significantly decreased during this time.

30-Day Measure (see Table 100)

- In 2008, plan rates for follow-up care within 30 days ranged from 67-80 percent, with a Maryland average of 73 percent. The same two plans that performed significantly above the Maryland average for follow-up within 7 days also performed significantly above average for follow-up within 30 days. Only one plan performed significantly below the Maryland average, the remainder of plans received average scores.
- The Maryland HMO/POS average decreased 2 percentage points between 2006 and 2008. Two plans significantly decreased their rates during this period, while one plan significantly increased its rate; the remainder of the plans experienced no significant change.

Table 99: Follow-Up After Hospitalization for Mental Illness, 7 Days, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**58%**	**57%**	**54%**	**2%**			
Aetna	55%	53%	48%	⇓	★★	★	★
BlueChoice	62%	60%	59%	⇔	★★★	★★★	★★★
CIGNA	59%	60%	48%	⇓	★★	★★	★
Coventry	50%	50%	46%	⇔	★	★	★
Kaiser Permanente	67%	69%	68%	⇔	★★★	★★★	★★★
M.D. IPA	57%	54%	56%	⇔	★★	★★	★★
OCI	59%	51%	54%	⇔	★★	★	★★

Table 100: Follow-Up After Hospitalization for Mental Illness, 30 Days, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**75%**	**74%**	**73%**	**-2%**			
Aetna	72%	72%	67%	⇔	★★	★★	★
BlueChoice	75%	76%	78%	⇔	★★	★★	★★★
CIGNA	76%	77%	69%	⇓	★★	★★	★★
Coventry	65%	69%	69%	⇔	★	★	★★
Kaiser Permanente	75%	76%	80%	⇑	★★	★★	★★★
M.D. IPA	77%	74%	72%	⇔	★★	★★	★★
OCI	83%	73%	73%	⇓	★★★	★★	★★

Legend

Change 2006–2008

⇑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
⇓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

PPO Results *(see Tables 101–102)*

7-Day Measure (see Table 101)

- In 2008, no PPO plan performed significantly different from the Maryland average of 46 percent. PPO plan scores ranged from 43-49 percent.

30-Day Measure (see Table 102)

- The Maryland PPO average in 2008 was 64 percent. One plan performed significantly above the Maryland average, while one plan performed significantly below. PPO plan rates ranged from 63-71percent.

Table 101: Follow-Up After Hospitalization for Mental Illness, 7 Days, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**46%**	
Aetna PPO	45%	★★
BluePreferred	43%	★★
CGLIC	46%	★★
MAMSI Life	49%	★★

Table 102: Follow-Up After Hospitalization for Mental Illness, 30 Days, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**64%**	
Aetna PPO	63%	★★
BluePreferred	56%	★
CGLIC	71%	★★★
MAMSI Life	66%	★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.

ANTIDEPRESSANT MEDICATION MANAGEMENT

Background

Many people who suffer from severe depression can benefit from pharmacological treatment; however, clinical guidelines stress the importance of effective clinical management of medications. A review of antidepressant efficacy found that among primary care patients initiating treatment, 25–30 percent discontinue treatment within one month—before therapeutic effects can be fully assessed. Within three months, which is before the acute treatment phase is complete, 40–50 percent of patients discontinue medication (Simon, 2002). Another 50 percent discontinue medications during the maintenance phase of treatment (Melartin et al., 2005).

Research has shown that discontinuation of antidepressant medication is influenced by various factors, which include, but are not limited to, sociodemographic characteristics, depression-related feelings/ characteristics (feelings of hopelessness), insurance benefits, and cultural systems (Croghan, Schoenbaum, Sherbourne, and Koegel, 2006).

According to a study analyzing when and why patients stop antidepressant treatment, 24 percent of patients did not tell their physician they stopped the medication. The probability of patients informing their physicians varied based on the individual reasons for cessation and the relationship between the patient and physician. Study results indicate the need for improved compliance guidelines, focusing on the stage of treatment, physician attitude, and information provided to patients (Demyttenaere, et al., 2001).

Measure Definition

The *Antidepressant Medication Management* measure assesses three different facets of successful pharmacological management of depression. Each facet is based on the same eligible population of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication.

1. *Optimal Practitioner Contacts for Medication Management*: The percentage of members who had at least three follow-up contacts with a practitioner during the Acute Treatment Phase (12 weeks). At least one of the three follow-up contacts must be with a prescribing practitioner.
2. *Effective Acute Phase Treatment*: The percentage of members who remained on the medication during the Acute Treatment Phase (12 weeks).
3. *Effective Continuation Phase Treatment:* The percentage of members who remained on an antidepressant drug for at least 180 days.

Data Collection Methodology

This measure is collected using Administrative Method.

Summary of Changes to HEDIS 2008

Requirements for identifying *Optimal Practitioner Contacts* are clarified; coding changes do not affect comparability to prior years' results.

HMO/POS Results

Optimal Practitioner Contacts for Medication Management (see Table 103)

- From 2006–2008, the Maryland HMO/POS average decreased by one percentage point. Two plans showed a statistically significant increase in rates, three plans did not show any significant change, and two plans showed a statistically significant decrease in rates.
- In 2008, rates ranged from 15–28 percent, with one plan receiving an above-average score, three plans receiving average scores, and three plans receiving below-average scores.

Table 103: Antidepressant Medication Management, Optimal Practitioner Contacts, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**20%**	**19%**	**19%**	**-1%**			
Aetna	22%	20%	21%	⇔	★★	★★	★★
BlueChoice	12%	14%	15%	🡅	★	★	★
CIGNA	23%	19%	17%	🡇	★★	★★	★★
Coventry	18%	17%	15%	⇔	★★	★★	★
Kaiser Permanente	18%	21%	28%	🡅	★★	★★	★★★
M.D. IPA	25%	24%	21%	⇔	★★★	★★★	★★
OCI	22%	19%	17%	🡇	★★★	★★	★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Effective Phase Treatment (see Table 104)

- Most plans experienced no significant change in rate from 2006–2008, although one plan significantly increased its rate by 6 percentage points during this period.
- In 2008, rates ranged from 60–69 percent, with one plan receiving an above-average score, four plans receiving average scores, and two plans receiving below-average scores.

Table 104: Antidepressant Medication Management, Effective Acute Phase Treatment, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**62%**	**63%**	**64%**	**3%**			
Aetna	64%	67%	67%	⇔	★★	★★★	★★
BlueChoice	68%	68%	69%	⇔	★★★	★★★	★★★
CIGNA	61%	61%	64%	⇔	★★	★★	★★
Coventry	62%	61%	64%	⇔	★★	★★	★★
Kaiser Permanente	56%	56%	62%	🡅	★	★	★
M.D. IPA	58%	63%	60%	⇔	★★	★★	★
OCI	62%	65%	64%	⇔	★★	★★	★★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Effective Continuation Phase Treatment (see Table 105)

- From 2006–2008, the Maryland HMO/POS average increased by 4 percentage points to 48 percent. Three plans significantly increased their rates during this period; the remaining plans saw no significant change.
- In 2008, rates ranged from 46–54 percent. One plan received an above-average score, five plans received average scores, and one plan received a below-average score.

Table 105: Antidepressant Medication Management, Effective Continuation Phase Treatment, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**44%**	**47%**	**48%**	**4%**			
Aetna	50%	49%	50%	⇔	★★★	★★	★★
BlueChoice	41%	52%	54%	🡅	★	★★★	★★★
CIGNA	44%	49%	48%	⇔	★★	★★	★★
Coventry	47%	48%	46%	⇔	★★	★★	★★
Kaiser Permanente	40%	38%	46%	🡅	★	★	★
M.D. IPA	40%	46%	46%	🡅	★★	★★	★★
OCI	43%	48%	46%	⇔	★★	★★	★★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

PPO Results

Optimal Practitioner Contacts for Medication Management (see Table 106)

- In 2008, PPO rates ranged from 19–28 percent, with one plan receiving an above-average score and all other plans receiving average scores.

Table 106: Antidepressant Medication, Optimal Practitioner Contacts, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**23%**	
Aetna PPO	21%	★★
BluePreferred	22%	★★
CGLIC	19%	★★
MAMSI Life	28%	★★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.

Effective Phase Treatment (see Table 107)

- In 2008, PPO rates ranged from 66–72 percent, with all plans receiving average scores.

Effective Continuation Phase Treatment (see Table 108)

- In 2008, PPO rates ranged from 51–55 percent, with all plans receiving average scores.

Table 107: Antidepressant Medication Management, Effective Acute Phase Treatment, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**68%**	
Aetna PPO	66%	★★
BluePreferred	66%	★★
CGLIC	68%	★★
MAMSI Life	72%	★★

Table 108: Antidepressant Medication Management, Effective Continuation Phase Treatment, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland PPO Average	**54%**	
Aetna PPO	51%	★★
BluePreferred	55%	★★
CGLIC	55%	★★
MAMSI Life	53%	★★

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland PPO average.
★★ = Individual plan rate equivalent to the Maryland PPO average.
★ = Individual plan rate significantly worse than the Maryland PPO average.

Notes

- PPO health plans collected and provided data for public reporting for the first time in 2008; therefore, trend data are not available.

IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES

Background

Untreated substance abuse and addiction can result in considerable costs and stress to families and communities. Research has found numerous effective approaches for treating substance abuse that help individuals obtain long-term control over their lives (CDC, 2002). According to the American Society of Addiction Medicine, there are five levels of care: medically-managed intensive inpatient, residential, intensive outpatient, outpatient, and early intervention. Similar to other chronic conditions, the drug addiction treatment process is multifaceted. It can include various types of treatments and should take into account the mental and physical health of the individual, so that it best meets his or her needs.

An estimated 313,000 Maryland residents over the age of 12 reported alcohol dependence or abuse between 2004 and 2005, and an estimated 125,000 reported illicit drug dependence or abuse (SAMHSA, 2008).

Measure Definition

Identification of Alcohol and Other Drug Services measures the number and percentage of members with an alcohol or other drug (AOD) claim. These claims contain a diagnosis of AOD abuse or dependence and one of the following AOD-related services during the measurement year.

- Inpatient hospital treatment
- Intermediate care
- Ambulatory treatment

Summary of Changes to HEDIS 2008

Coding changes to this measure do not affect comparability to prior years' results.

HMO/POS Results *(see Table 109)*

- Across Maryland HMO/POS plans, 0.90 percent of all members with substance abuse coverage had alcohol or other drug claims for services rendered in 2007.
- Rates of members who received any service ranged from 0.62–1.28 percent.

Table 109: Identification of AOD Services- Percentage of Members Receiving Services, 2008 Results

	Any Services		Inpatient Services		Intermediate Services		Ambulatory Services	
	Number	%	Number	%	Number	%	Number	%
Maryland HMO/ POS Average	**34,440**	**0.90%**	**10,073**	**0.27%**	**3,799**	**0.11%**	**28,159**	**0.75%**
Aetna	25,704	0.74%	9,444	0.27%	2,772	0.08%	19,488	0.56%
BlueChoice	81,408	1.10%	26,244	0.35%	10,608	0.14%	60,156	0.81%
CIGNA	12,876	0.67%	3,516	0.18%	1,416	0.07%	10,164	0.53%
Coventry	18,132	1.28%	6,420	0.45%	2,748	0.19%	15,624	1.10%
Kaiser Permanente	57,024	1.10%	13,020	0.25%	2,580	0.05%	50,748	0.98%
M.D. IPA	13,092	0.62%	3,948	0.19%	1,668	0.08%	11,424	0.54%
OCI	32,844	0.80%	7,920	0.19%	4,800	0.12%	29,508	0.72%

Note

- The sum of the number of members who receive various services does not equal the number of members who received any service because some members receive more than one type of service.

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

Background

Drug and alcohol addiction are treatable, complicated conditions that place a burden on the person who is addicted and their family, and on society at large. To achieve the ultimate goal of abstinence, most persons addicted to drugs and alcohol require comprehensive treatment that may include behavioral therapy, medication, or a balance of both (NIDA, 2008).

Results from the 2007 National Survey on Drug Use and Health (SAMHSA, 2008):

- 23.2 million Americans (9.4 percent of the population) aged 12 and older had a problem with alcohol or drug use and needed treatment. Only 2.4 million people in this population, or 1 percent, received treatment in a hospital, substance abuse rehabilitation center, or mental health clinic. Of the 20.8 million Americans who did not receive substance abuse treatment, 1.3 million persons said they believed they needed treatment. Of this 1.3 million, 380,000 said they made an effort to obtain treatment.
- 53.3 percent of those who received substance use treatment reported using their savings or earnings to pay for their most recent specialty treatment. 34.9 percent reported using private health insurance. Other sources of payments included public assistance, Medicare, Medicaid, or help from family and friends.
- In 2007, there were 65,239 admissions to facilities licensed by the state for substance abuse treatment in Maryland.

Measure Definition

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure assesses the degree to which members identified with alcohol and other drug (AOD) dependence initiate and engage in treatment.

1. *Initiation:* The percentage of members diagnosed with AOD dependence who initiate treatment through either:
   - An inpatient admission, ***or***
   - Outpatient treatment and additional AOD treatment within 14 days.
2. *Engagement:* The percentage of members diagnosed with AOD dependence who receive two additional AOD services within 30 days after treatment initiation.

Data Collection Methodology

This measure is collected using the Administrative Method.

Summary of Changes to HEDIS 2008

Age stratifications are removed. Coding changes to this measure do not affect comparability to prior years' results.

HMO/POS Results

Initiation of Alcohol and Other Drug Dependence Treatment (see Table 110)

- Between 2006 and 2008, the Maryland HMO/POS average increased by three percentage points. Three plans had a statistically significant increase in their rates, with one plan increasing by 10 percentage points. The remaining four plans had no significant change.
- In 2008, the Maryland average was 49 percent, while rates ranged from 35–68 percent. One plan received an above-average score, four plans received average scores, and two plans received below-average scores.

Table 110: Initiation of AOD Dependence Treatment, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**46%**	**42%**	**49%**	**3%**			
Aetna	48%	49%	50%	⇔	★★	★★★	★★
BlueChoice	31%	23%	35%	🡅	★	★	★
CIGNA	48%	46%	47%	⇔	★★	★★★	★★
Coventry	38%	46%	48%	🡅	★	★★★	★★
Kaiser Permanente	65%	45%	68%	🡅	★★★	★★★	★★★
M.D. IPA	46%	44%	46%	⇔	★★	★★	★★
OCI	43%	41%	43%	⇔	★	★★	★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Engagement of AOD Dependence Treatment (see Table 111)

- From 2006–2008, the Maryland HMO/POS average increased by 3 percentage points. Four of seven plans significantly increased their rates, while the remaining three plans experienced no significant change.
- While plans continue to show much lower alcohol and drug treatment engagement rates than seen in *Initiation of AOD Dependence Treatment*, each plan increased its rates since last year.
- Two plans received above average scores, two plans received average scores, and three plans received below-average scores.

Table 111: Engagement of AOD Dependence Treatment, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**14%**	**11**	**17%**	**3%**			
Aetna	12%	15%	16%	↑	★	★★★	★
BlueChoice	19%	9%	24%	↑	★★★	★	★★★
CIGNA	10%	11%	18%	↑	★	★★	★★
Coventry	10%	8%	13%	⇔	★	★	★
Kaiser Permanente	22%	13%	22%	⇔	★★★	★★★	★★★
M.D. IPA	10%	10%	13%	⇔	★	★★	★
OCI	15%	14%	18%	↑	★★	★★★	★★

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER MEDICATION

Background

Attention-deficit/hyperactivity disorder (ADHD) is one of the most commonly treated neurobehavioral conditions among children (McDonnell et al., 2008). Characterized by impulsivity, inattentiveness, and hyperactivity, ADHD can disrupt functioning and relationships when not treated (NIMH, 2008). Children with ADHD can be treated in a variety of ways, including medication and psychotherapy; however, follow-up care and surveillance is a key aspect of management.

The American Academy of Family Physicians recommends that children taking medication for ADHD have routine visits with their doctor. Visits provide opportunities for physicians to ensure effective dosages and monitor potential side effects (2002).

Despite clinical guidelines studies have shown that children diagnosed with ADHD often do not have routine follow-up visits. In one study, only 53 percent of surveyed physicians reported routine follow-up visits for children diagnosed with ADHD (Rushton et al., 2004). It has also been reported that only 25 percent of patients have a follow-up visit with their primary care physician in the 30 days following the initial ADHD medication prescription; this number is only 4 percent higher in psychiatric settings (Harpaz-Rotem and Rosenheck, 2006).

Following up with children on ADHD medications is not only important for the surveillance of side-effects and dosage effectiveness, it also has an effect on medical costs. Among children diagnosed with ADHD, a significant decline in emergency room visits and costs have been seen for those with more follow-up visits for medication treatment (Leibson et al., 2006).

Measure Definition

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication produces two rates that indicate the frequency of follow-up care.

1. *Initiation Phase Management:* The percentage of members 6–12 years of age who had a prescription dispensed for ADHD medication and one follow-up visit with a non-mental health or mental health practitioner with prescribing authority during the Initiation Phase (30 days).
2. *Continuation and Maintenance (C&M) Phase:* The percentage of members 6–12 years of age who had an ambulatory prescription dispensed for ADHD medication, remained on the medication for at least 210 days, and had at least two additional follow-up visits with a non-mental health or mental health practitioner within 9 months after the Initiation Phase ended.

Summary of Changes to HEDIS 2008

Intensive outpatient and partial hospitalization visits satisfy the intention of the measure to assess follow-up visits. Coding changes do not affect comparability to the prior year's results for the *Initiation Phase* numerator. In 2007, the age and eligible population criteria were clarified for the *Continuation and Maintenance (C&M) Phase* numerator. Changes to the measure specification may have had an impact on rates; therefore, the *C&M Phase* plan-specific results were not reported in 2007.

HMO/POS Results

Initiation of Follow-Up Care for Children Prescribed ADHD Medication (see Table 112)

- In 2008, the Maryland HMO/POS average was 32 percent, showing no change from the 2007 average rate. During this year, rates ranged from 25-39 percent.
- Three plans received scores above the Maryland average, one plan received an average score and three plans received below-average scores.

Table 112: Initiation of Follow-Up Care for Children Prescribed ADHD Medication

	Comparison of Absolute Rates		Comparison of Relative Rates	
	2007	2008	2007	2008
Maryland HMO/POS Average	**32%**	**32%**		
Aetna	31%	37%	★★	★★★
BlueChoice	34%	29%	★★	★
CIGNA	29%	32%	★★	★★
Coventry	29%	25%	★★	★
Kaiser Permanente	27%	28%	★	★
M.D. IPA	39%	39%	★★★	★★★
OCI	36%	36%	★★★	★★★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Continuation and Maintenance of Follow-Up Care for Children Prescribed ADHD Medication (see Table 113)

- In 2008, the Maryland HMO/POS average was 45 percent. One plan scored significantly above the average with a rate of 87 percent, nearly double the Maryland average. Most plans received average scores; only two plans received scores significantly below the Maryland average.

Table 113: Continuation of Follow-Up Care for Children Prescribed ADHD, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland HMO/ POS Average	**45%**	
Aetna	39%	★★
BlueChoice	87%	★★★
CIGNA	32%	★
Coventry	23%	★
Kaiser Permanente	43%	★★
M.D. IPA	51%	★★
OCI	41%	★★

Legend

Change 2006–2008

🡅 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡇 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- Changes in HEDIS 2007 affected plan-specific reporting for the *C&M Phase* 2007 rates; therefore, only 2008 rates are reported.

BEHAVIORAL HEALTHCARE PROVIDERS

Background

This measure was developed by the MHCC to collect data on the number and types of behavioral healthcare providers available to members through their plan. Many health plans contract with MBHOs to provide care to some or all of their members. These organizations, specializing in mental health and chemical dependency services, have their own network of physicians and other behavioral health practitioners. Members accessing behavioral health services through an MBHO may have specific policies for obtaining referrals, limiting coverage, and assessing copayments that may differ from the policies for accessing medical care through the health plan.

When care is delivered and no problems arise, the contractual relationship between a health plan and an MBHO may be transparent to members. Obtaining health plan referrals for behavioral health services has been an area of great concern for health plan members.

Measure Definition

This MHCC-specific *Behavioral Healthcare Providers* access measure reports the total number of providers per 1,000 members with behavioral health benefits. Only providers who serve members enrolled within the service area of the health plan are counted. Providers may be employed by the health plan, have a contractual relationship with the health plan, or have a contractual relationship with the MBHO responsible for managing and providing care for health plan members. The total number of providers includes the following.

- Psychiatrists
- Psychologists
- Other behavioral health providers (includes certified professional counselors, social workers, and nurse psychotherapists)

HMO/POS Results

The measure shows a comparison of the total provider network available to members of the various plans. The number of providers available is compared for an equal number of members across each plan and reported as providers per 1,000 members. A larger number of providers may improve access to care by giving members more choices in who they see, appointment times, and locations.

Total Providers (see Table 114)

- The Maryland HMO/POS average number of total providers is 15.3 per 1,000 members. Rates ranged from 2.4–29.9 providers per 1,000 members.

Table 114: **Plans' Total Number of Behavioral Healthcare Providers**

Health Plan	MBHO	Total Number of Behavioral Health Providers in MBHO and Plan Network as of Spring 2007 (per 1,000 Members)*
Maryland HMO/POS Average		**15.3**
Aetna	Aetna Behavioral Health	12.1
BlueChoice	Magellan Tristate Care Management Center	4.2
CIGNA	CIGNA Behavioral Health-	20.1
Coventry	United Behavioral Health-Atlanta	29.9
Kaiser Permanente**	Plan Network Providers	2.7
	APS	2.4
M.D.IPA	United Behavioral Health-Philadelphia	27.8
OCI	United Behavioral Health-Philadelphia	23.2

Notes

* Number of providers is based on the service area of the plan. The MBHO network may have a larger number of practitioners than reported in this report.

** Depending on the location of the member's personal physician, services are administered by either Kaiser Permanente directly or through an arrangement with APS Healthcare. Kaiser's behavioral health network comprises of APS Healthcare and Kaiser practitioners.

Psychiatrists (MD) Board Certification (see Table 115)

- The Maryland HMO/POS average for the percentage of psychiatrists who are board certified is 72 percent. Rates ranged from 58–77 percent.

Table 115*: *Plans' Percentage of Psychiatrists Who Are Board Certified

Health Plan	MBHO	Percentage of Psychiatrists Who Are Board Certified
Maryland HMO/POS Average		**72%**
Aetna	Aetna Behavioral Health	58%
BlueChoice	Magellan Tristate Care Management Center	72%
CIGNA	CIGNA Behavioral Health	74%
Coventry	United Behavioral Health	76%
Kaiser Permanente**	Plan Network Providers	77%
	APS	71%
M.D. IPA	United Behavioral Health-Philadelphia	75%
OCI	United Behavioral Health-Philadelphia	74%

MENTAL HEALTH UTILIZATION—PERCENTAGE OF MEMBERS RECEIVING ANY SERVICES

Measure Definition

Mental Health Utilization—Percentage of Members Receiving Any Services measures the percentage of members who received any of the following types of mental health services.

- Inpatient hospital treatment
- Intermediate care (a level of care where a patient may live at home and visit a therapeutic institution during the day)
- Ambulatory treatment

This measure is intended to provide information about access to mental health services. Rates are expressed as percentages.

Summary of Changes to HEDIS 2008

Coding changes to this measure do not affect comparability to prior years' results.

HMO/POS Results *(see Table 116)*

- Across Maryland HMO/POS plans, 4.98 percent of all members with behavioral health coverage received some type of mental health service in 2008.
- Rates of members receiving any service ranged from 4.63—5.57 percent.

Rates for hospital treatment (inpatient), intermediate care, and ambulatory treatment are included in the report to facilitate comparison and analysis by plans, providers, and other organizations.

Table 116: Mental Health Utilization- Any Services, 2008 Results

	Any		Inpatient		Intermediate		Ambulatory	
	Number	%	Number	%	Number	%	Number	%
Maryland HMO/ POS Average	**180,903**	**4.98%**	**8,321**	**0.23%**	**2,458**	**0.07%**	**178,572**	**4.92%**
Aetna	165,492	4.63%	7,200	0.20%	1,896	0.05%	163,536	4.57%
BlueChoice	378,564	5.09%	16,380	0.22%	5,436	0.07%	374,028	5.03%
CIGNA	103,800	5.41%	4,620	0.24%	960	0.05%	102,756	5.36%
Coventry	79,080	5.57%	4,284	0.30%	1,716	0.12%	77,580	5.47%
Kaiser Permanente	246,984	4.75%	12,456	0.24%	2,388	0.05%	243,300	4.68%
M.D. IPA	100,128	4.74%	3,996	0.19%	1,536	0.07%	99,000	4.68%
OCI	192,276	4.70%	9,312	0.23%	3,276	0.08%	189,804	4.64%

Notes

- The sum of the number of members who received various services does not equal the number of members who received "any service" because some members received more than one type of service.

USE OF SERVICES

USE OF SERVICES

Overview

This section presents results for measures in the 2008 HEDIS *Use of Services* domain that MHCC required Maryland HMO/POS plans to report in 2008. Descriptive indicators and rates related to facility utilization include information on inpatient discharges and average length of stay (ALOS), and ambulatory care. Monitoring utilization is essential for any health plan; the *Use of Services* rates included in this section can be valuable for analytical purposes.

Use of Services measures are collected as a way to identify variation in utilization levels. Although there are no utilization measure standards, plans can use these results for initial verification of outlier rates. Outlier rates indicate that something unusual is occurring with the plan, its providers, or its members, or that the plan's data collection system is flawed. The concept behind collecting these data is that, once identified, HMO/POS plans can target areas for further study or improvement.

Results for measures in this domain are affected by many member characteristics that can vary greatly among health plans, including age, gender, current medical condition, socioeconomic status, and race. *Rates that are three standard deviations from the mean are not included.*

For *Frequency of Use* measures, rates of utilization are often expressed as rates of service used per 1,000 member months, or they may be converted to rates of service used per year. Unlike *Effectiveness of Care* and *Access/Availability of Care* measures, continuous enrollment criteria do not factor into most of these rate calculations. The number of member months is the sum of the months in which each member is enrolled in the plan each year. For plans with stable memberships, the reported number of member years is close to the number of members enrolled at any point during the year. This comparison may not apply to plans with growing or declining enrollment.

Rates are not correlated with performance for these measures.

Measures Reported in Domain:

- Ambulatory Care
- Antibiotic Utilization
- Frequency of Selected Procedures
- Inpatient Utilization- General Hospital/ Acute Care
- Inpatient Utilization- Nonacute Care
- Outpatient Drug Utilization

Factors Affecting Interpretation of Results

Several factors complicate interpretation of the *Use of Services* measures. Readers should consider the following.

- Utilization is significantly influenced by characteristics of the member population. HEDIS rates are not risk adjusted, so variation in plan results may be affected by real differences in member health, race, education, and socioeconomic status. These differences may be most obvious in rates of utilization for various procedures.
- Standards or accepted targets for these rates do not exist. High rates *could* indicate overutilization, while low rates *could* indicate underutilization.
- Health plan utilization departments do not always measure utilization using the same method as HEDIS specifications, so health plans do not have comparable internal rates to determine how reasonable results are.

As a result of the factors listed above, relative rates (i.e., above/below average scores) *are not* presented for rates of procedures. Interplan comparison is not appropriate. In addition, given the large number of these measures, only 2008 rates are presented. Rates for previous years can be found in the *Comprehensive Report* for the year of interest.

INPATIENT UTILIZATION—GENERAL HOSPITAL/ACUTE CARE

Measure Definition

The *Inpatient Utilization—General Hospital/Acute Care* measure reports general hospital rate of utilization of for treatment of acute conditions and ALOS. Three separate rates are reported: all patients (Total), medical patients (Medicine), and surgical patients (Surgery).

Notes

When interpreting this information, it is important to remember that these results are not risk adjusted for demographic characteristics or severity of illness. Neither availability nor use of outpatient alternatives is considered.

Results *(see Table 117)*

- The total average number of discharges per 1,000 members and total ALOS days had a small change between 2007 and 2008. Average total discharges per 1,000 members was 52.2 members in 2007 and 52.9 members in 2008. ALOS was 3.5 in 2007; in 2008 it was 3.6.
- Rates of *medical* discharges per 1,000 members ranged from 20.9–25.4; rates for *surgical* discharges ranged from 13.4–22.7.
- ALOS ranged from 2.8–4.8 for *medical* and 3.7–4.9 for *surgical patients*.

Table 117: Inpatient Utilization- General Hospital/Acute Care, 2008 Results

	Discharges/1,000 Members			ALOS (Days)		
	Total	Medical	Surgical	Total	Medical	Surgical
Maryland HMO/ POS Average	**52.9**	**23.5**	**17.6**	**3.6**	**3.5**	**4.2**
Aetna	60.0	25.4	18.5	3.4	3.2	4.5
BlueChoice	59.8	21.2	22.6	3.3	2.8	4.1
CIGNA	51.3	20.8	17.6	3.9	3.9	4.6
Coventry	63.9	30.0	22.7	3.2	3.0	3.7
Kaiser Permanente	51.9	24.0	14.5	4.3▲	4.8▲	4.9
M.D. IPA	41.4▼	22.2	13.6▼	3.6	3.6	4.0
OCI	41.7▼	20.9	13.4▼	3.3	3.1	4.0

Legend

▲ Plan rate is higher than 90 percent of other plans, nationally.
▼ Plan rate is lower than 90 percent of other plans, nationally.

INPATIENT UTILIZATION—NONACUTE CARE

Measure Definition

The *Inpatient Utilization—Nonacute Care* measure reports the rate of utilization and ALOS for inpatient, nonacute care. Inpatient, nonacute care includes inpatient care received in the following facilities: hospice, nursing home, rehabilitation, skilled nursing facilities, transitional, and respite care. Mental health and chemical dependency facilities are excluded. Rates are per 1,000 members.

Notes

When interpreting this information, it is important to remember that results are not risk-adjusted for demographic characteristics and use of outpatient alternatives.

Results *(see Table 118)*

- In 2008, Maryland plans reported, on average, 1.9 discharges per 1,000 members; discharge rates ranged from 1.2–4.2 per 1,000 members.
- On average, Maryland plans reported 13.9 days as the ALOS.

Table 118: Inpatient Utilization- Nonacute Care, 2008 Results

	Discharges/1,000 Members	ALOS (Days)
Maryland HMO/POS Average	**1.9**	**13.9**
Aetna	1.6	18.2
BlueChoice	1.4	13.4
CIGNA	1.9	14.9
Coventry	1.6	12.8
Kaiser Permanente	4.2▲	12.9
M.D. IPA	1.3	12.7
OCI	1.2	12.4

Legend

▲ Plan rate is higher than 90 percent of other plans, nationally.
▼ Plan rate is lower than 90 percent of other plans, nationally.

AMBULATORY CARE

Measure Definition

The *Ambulatory Care* measure reports member use of ambulatory services, including outpatient visits, emergency department visits, ambulatory surgeries/procedures, and observation room stays that result in discharge. Rates are per 1,000 members.

Notes

An **outpatient visit** is a face-to-face encounter between the practitioner and patient for routine care. It provides a reasonable proxy for professional ambulatory encounters.

ED visits are sometimes used as a substitute for ambulatory clinic encounters. Although patient behavior is a factor in the decision to use an ED rather than a clinic or physician's office, the decision also may result from insufficient access to primary care. A health plan that provides adequate preventive services and effectively manages ambulatory treatment of patients by offering alternative treatment benefits, such as urgent care coverage, should be able to keep the number of ED visits relatively low. Ambulatory surgeries include procedures performed at a hospital outpatient facility or at a free-standing surgery center; office-based surgeries/procedures are excluded from this measure.

The increasing use of outpatient surgery as an alternative to inpatient surgery can create data interpretation issues. For hospital organizations with semiattached ambulatory surgery centers, the distinction between service venues may be confused during data processing.

Results *(see Table 119)*

- The Maryland HMO/POS average number of outpatient visits decreased from 3,914 in 2007 to 3,909 in 2008. Rates ranged from 3,575–4,304 per 1,000 members.
- The Maryland HMO/POS average number of ED visits decreased from 202 in 2007 to 198 in 2008. Rates ranged from 192–260 visits per 1,000 members.
- The Maryland HMO/POS average number of ambulatory surgeries/procedures decreased from 111 in 2007 to 110 in 2008.

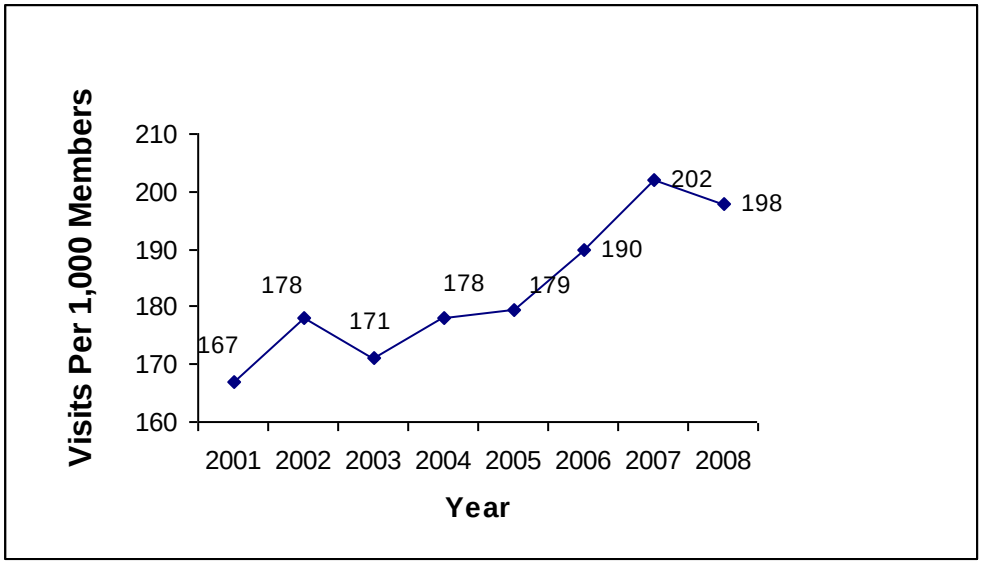
Table 119: Ambulatory Care, 2008 Results – Visits/1,000 Members

	Outpatient	ED	Ambulatory Surgery/Procedure
Maryland HMO/POS Average	**3,909**	**198**	**110**
Aetna	3,616	199	98
BlueChoice	3,737	260	58▼
CIGNA	4,164	200	119
Coventry	3,944	192	158
Kaiser Permanente	4,304▲	128▼	58▼
M.D. IPA	4,026	198	144
OCI	3,575	209	134

Legend

▲ Plan rate is higher than 90 percent of other plans, nationally.
▼ Plan rate is lower than 90 percent of other plans, nationally.

Figure 1: Emergency Department, Trending



OUTPATIENT DRUG UTILIZATION

Measure Definition

The *Outpatient Drug Utilization* measure reports the number of prescriptions dispensed per member, per year (PMPY) and the average cost of prescriptions per member, per month (PMPM). Only members whose benefits include prescription drug coverage through their HMO/POS plans are included. This measure excludes drugs that members are given in the hospital; it includes only prescriptions covered by the health plan. Because many employers "carve out" drug benefits from their contracts with health plans, data do not reflect a true picture of prescription drug use by all plan members.

Notes

Plans accredited by NCQA have met the standards for pharmaceutical management, which includes formulary development. Information about NCQA's pharmacy management standards is included in the *External Accreditation* section of this report.

Results (*see Table 120*)

- In 2008, HMO/POS members in Maryland, on average, received 11.6 prescriptions for the year, at a cost of $56.21 per month. In 2007, the rate was 11.2 prescriptions PMPY. Average monthly cost has increased $3.68 per member.

Table 120: Outpatient Drug Utilization, 2008 Results

	Prescriptions/Member/Year	Cost of Prescriptions/ Member/Month
Maryland HMO/POS Average	**11.6**	**$56.21**
Aetna	10.2	$55.02
BlueChoice	10.9	$59.80
CIGNA	12.0	$62.28
Coventry	12.8	$57.85
Kaiser Permanente	11.6	$32.15
M.D. IPA	12.8	$66.97
OCI	11.2	$59.43

FREQUENCY OF SELECTED PROCEDURES

Background

The *Frequency of Selected Procedures* measure reports utilization rates for several (mostly surgical) procedures that are performed frequently and contribute substantially to health care costs. Considerable variation exists in how often procedures are performed. Rates for these measures are likely to be strongly influenced by how a health plan manages care, as well as by the demographic characteristics of the plan's members. Data were collected using the Administrative Method.

Measure Definition

Utilization rates for the following procedures.

- *Myringotomy:* Incision of the eardrum to allow insertion of ventilating tubes to treat chronic ear infections.
- *Tonsillectomy/Tonsillectomy and Adenoidectomy:* Surgical removal of the tonsils or tonsils and adenoids.
- *Nonobstetric Dilation and Curettage (D&C):* Dilation and surgical cleansing of the surface of the uterus.
- *Hysterectomy:* Surgical removal of the uterus.
- *Cholecystectomy, open:* Surgical removal of the gallbladder through an abdominal incision.
- *Cholecystectomy, closed (laparoscopic):* Surgical removal of the gallbladder with a laparoscope.
- *Angioplasty:* Repairing or replacing damaged blood vessels using lasers or tiny inflatable balloons at the end of a catheter that is inserted into the vessels.
- *Cardiac Catheterization:* Procedure used to diagnose the severity and extent of coronary artery disease.
- *Coronary Artery Bypass Graft (CABG):* Surgical procedure used to treat coronary heart disease by grafting a portion of a vein from the patient to replace the portion of the damaged or blocked coronary artery.
- *Prostatectomy:* Surgical removal of the prostate gland.
- *Back Surgery:* Spinal fusions and disc surgeries, including laminectomies with and without disc removal.
- *Mastectomy:* Surgical removal of all or most of the breast.
- *Lumpectomy:* Surgical removal of a small tumor from the breast.

Results *(see Tables 121–126)*

Results for these procedures are presented in the tables on the following pages. To create a standardized result across different sized plans, results appear as rates/1,000 (i.e., the number of times a procedure was performed per 1,000 plan members). This makes it possible to compare very large and very small plans to each other. In most cases, rates are displayed by age and gender because these two factors have much to do with health status and types of health problem for which people seek care.

Rates for selected procedures included in the *Comprehensive Report* facilitate comparison and analysis by plans, providers, and other organizations. As noted in the *Overview* section at the beginning of this chapter, utilization rates are significantly influenced by the characteristics of the plan's member population and are vulnerable to data completeness issues. Rates are not risk-adjusted. There is no accepted standard or target for utilization measures; therefore, relative rates are not calculated and interplan comparison is not made here. Only 2008 rates are presented. Rates for previous years can be found in the *Comprehensive Report* published for the year of interest.

Table 121: Frequency of Myringotomies and Tonsillectomies, 2008 Results

Procedures/1,000 Applicable Population				
	MYR 0–4 Years M&F	**MYR 5–19 Years M&F**	**TA 0–9 Years M&F**	**TA 10–19 Years M&F**
Maryland HMO/POS Average	**41.1**	**3.1**	**7.9**	**3.1**
Aetna	41.6	2.7	7.1	2.6
BlueChoice	20.4▼	2.1	8.1	3.8
CIGNA	61.8	4.4	9.1	3.5
Coventry	62.7	4.6	10.9	4.1
Kaiser Permanente	9.4▼	1.0▼	4.6▼	1.7▼
M.D. IPA	46.0	2.7	7.5	2.6
OCI	45.8	4.2	7.8	3.6

Notes

MYR = Myringotomy

TA = Tonsillectomy or Tonsillectomy and Adenoidectomy

M&F = Male and Female

Legend

▲ Plan rate is higher than 90 percent of other plans, nationally.
▼ Plan rate is lower than 90 percent of other plans, nationally.

Table 122: Frequency of D&C and Hysterectomies, 2008 Results

Procedures/1,000 Female Applicable Population						
	D&C 15–44 Years	**D&C 5–19 Years**	**HYS-ab 15–44 Years**	**HYS-ab 45–64 Years**	**HYS-vag 15–44 Years**	**HYS-vag 45–64 Years**
Maryland HMO/POS Average	**3.2**	**4.2**	**3.6**	**5.3**	**1.7**	**2.6**
Aetna	3.4	4.7	3.6	5.7	1.8	3.1
BlueChoice	3.5	4.6	3.1	5.8	1.8	3.0
CIGNA	2.3	3.3	3.5	4.8	2.2	2.3
Coventry	4.6▲	5.5▲	4.7	4.7	1.8	2.6
Kaiser Permanente	0.5	1.1▼	3.0	5.3	0.4▼	1.1
M.D. IPA	3.8	5.2	3.7	5.9	1.9	3.1
OCI	4.0	4.8	3.4	4.9	2.0	2.9

Notes

D&C = Dilation & Curettage

HYS-ab = Hysterectomy—Abdominal

HYS-vag = Hysterectomy—Vaginal

Table 123: Frequency of Cholecystectomies, 2008 Results

Procedures/1,000 Applicable Population						
	Chol-o 30–64 Years Male	**Chol-o 15–44 Years Female**	**Chol-o 45–64 Years Female**	**Chol-c 30–64 Years Male**	**Chol-c 15–44 Years Female**	**Chol-c 45–64 Years Female**
Maryland HMO/POS Average	**0.3**	**0.1**	**0.3**	**2.0**	**4.3**	**5.2**
Aetna	0.2	0.1	0.5	1.5	3.5	4.6
BlueChoice	0.4	0.2	0.3	2.1	4.6	5.4
CIGNA	0.2	0.2	0.2	2.2	4.9	6.1
Coventry	0.2	0.1	0.3	2.2	5.1	5.8
Kaiser Permanente	0.3	0.2	0.4	1.1▼	2.8▼	3.3▼
M.D. IPA	0.2	0.1	0.3	2.4	4.3	5.3
OCI	0.2	0.1	0.3	2.3	4.9	6.0

Notes

Chol-o = Cholecystectomy—Open

Chol-c = Cholecystectomy—Closed

Legend

▲ Plan rate is higher than 90 percent of other plans, nationally.
▼ Plan rate is lower than 90 percent of other plans, nationally.

Table 124: Frequency of Back Surgeries, 2008 Results

Procedures/1,000 Eligible Population				
	20–44 Years Male	**20–44 Years Female**	**45–64 Years Male**	**45–64 Years Female**
Maryland HMO/POS Average	**2.3**	**2.0**	**5.2**	**4.6**
Aetna	1.9	1.7	5.1	4.2
BlueChoice	2.4	2.4	5.7	5.0
CIGNA	2.7	2.1	6.0	5.1
Coventry	2.5	2.6	5.8	4.7
Kaiser Permanente	1.1▼	1.1	4.7	3.2
M.D. IPA	2.7	1.7	4.5	4.8
OCI	2.6	2.3	4.9	5.3

Table 125: Frequency of Cardiac Procedures, 2008 Results

1,000 Eligible Population						
	Ang 45–64 Years Male	**Ang 45–64 Years Female**	**CC 45–64 Years Male**	**CC 45–64 Years Female**	**CABG 45–64 Years Male**	**CABG 45–64 Years Female**
Maryland HMO/POS Average	**6.4**	**2.3**	**9.8**	**7.2**	**2.3**	**0.7**
Aetna	6.1	2.8	10.4	7.8	2.3	0.5
BlueChoice	6.5	1.8	9.3	6.9	2.1	0.7
CIGNA	5.9	2.3	11.2	7.8	1.9	0.4
Coventry	9.1	3.8	12.3	9.7	2.6	1.2
Kaiser Permanente	3.8▼	1.4	5.6▼	3.5	2.1	0.5
M.D. IPA	6.1	1.7	10.1	7.0	2.5	0.8
OCI	7.2	2.5	9.4	7.8	2.6	0.6

Legend

▲ Plan rate is higher than 90 percent of other plans, nationally.
▼ Plan rate is lower than 90 percent of other plans, nationally.

Notes

Ang = Angioplasty

CC = Cardiac catheterization

CABG = Coronary artery bypass graft

Table 126: Frequency of Mastectomies, Lumpectomies, and Prostatectomies, 2008 Results

Procedures/1,000 Eligible Population					
	Mastectomy		Lumpectomy		Prostatectomy
	15–44 Years Female	45–64 Years Female	15–44 Years Female	45–64 Years Female	45–64 Years Male
Maryland HMO/POS Average	**0.4**	**1.4**	**3.1**	**6.9**	**3.1**
Aetna	0.3	1.2	2.9	8.0	3.5
BlueChoice	0.3	1.5	3.2	6.6	2.6
CIGNA	0.6	1.6	3.2	6.6	3.6
Coventry	0.4	1.8	3.2	7.5	3.7
Kaiser Permanente	0.2	1.3	2.6	5.7	2.3
M.D. IPA	0.4	1.3	3.7	7.2	3.2
OCI	0.4	1.3	3.1	6.4	2.6

Notes

- Rates for mastectomy and lumpectomy apply only to female members in the individual age groups: ages 15–44 and 45–64 years.
- Rates for prostatectomy apply only to male members in the age group 45–64 years.

ANTIBIOTIC UTILIZATION

Measure Definition

The *Antibiotic Utilization* measure summarizes data on outpatient utilization of antibiotic prescriptions on the following.

- Total number of antibiotic prescriptions
- Average number of antibiotic prescriptions PMPY
- Total days supplied for all antibiotic prescriptions
- Average number of days supplied per antibiotic prescription
- Total number of prescriptions PMPY for antibiotics of concern
- Average number of prescriptions PMPY for antibiotics of concern
- Average number of antibiotics PMPY reported by drug class:
  - For selected "antibiotics of concern"
  - For all other antibiotics
- Percentage of antibiotics of concern of total antibiotic prescriptions
- During the measurement year, stratified by age and gender and reported for each product

Results *(See Table 127)*

The average total number of antibiotics prescribed by Maryland HMO/POS providers was 231,909; total antibiotic dispensing events for Maryland plans ranged from 96,216–471,064.

Table 127: Antibiotic Utilization, 2008 Results

	Total Antibiotic Dispensing Events
Maryland HMO/POS Average	231,909
Aetna	203,181
BlueChoice	471,064
CIGNA	146,243
Coventry	96,216
Kaiser Permanente	306,953
M.D. IPA	161,557
OCI	238,150

HEALTH PLAN
DESCRIPTIVE INFORMATION

HEALTH PLAN DESCRIPTIVE INFORMATION

Overview

This section contains results for the HEDIS 2008 *Health Plan Descriptive Information* measures that MHCC required Maryland commercial HMO/POS plans to report in 2008. It includes information on health plan structure, staffing, and enrollment. Purchasers and consumers are interested in the qualifications of doctors in the health plan and in member patterns, which can reveal potential signs of instability. For example, a sudden decrease in membership may indicate member dissatisfaction. Likewise, a sudden increase in membership due to merger/acquisition may raise questions about a plan's capacity to ensure access to care among its expanded membership base. The following measures address these issues.

Measures in Domain

- Board Certification
- Enrollment: Total, By State, By Product

BOARD CERTIFICATION

Background

Board certification can serve as a proxy to indicate physician quality. This measure shows the percentage of each health plan's physicians that sought and obtained board certification; it does not directly measure the quality of individual physicians. Virtually all medical specialty boards certify physicians who complete specified training and pass an examination in that specialty. Board certification shows that a physician has an extended knowledge of a specialty that may be important to purchasers and consumers.

Measure Definition

The *Board Certification* measure reports the percentage of the following *physician* practitioners who are board certified.

- Family Medicine
- Internal Medicine
- OB/GYN practitioners
- Pediatricians
- Psychiatrists
- All other practitioner specialists

Board certification refers to the various specialty certification programs of the American Board of Medical Specialties and the American Osteopathic Association.

Summary of Changes to HEDIS 2008

- Board certification criteria require active status. The *Primary Care Physicians* category has been replaced with *Family Medicine* and *Internal Medicine.*
- The *Pediatric Physician Specialists* category has been replaced with *Pediatricians* to capture the number of physicians whose board certification is active in pediatrics.

HMO/POS Results

Board Certification—All Practitioners (see Table 128)

- In 2008, board certification rates ranged from 76–84 percent across specialties. Certification rates were highest among pediatricians and lowest among OB/GYN practitioners.

Table 128: Board Certification, 2008 Results

Maryland HMO/POS Average	Family Medicine		Internal		OB-GYN		Pediatric		Other Specialists	
	82%		82%		76%		84%		79%	
Aetna	71%	★	80%	★	68%	★	83%	★★	71%	★
BlueChoice	79%	★	78%	★	75%	★★	81%	★	NR	NR
CIGNA	81%	★★	83%	★★★	76%	★★	85%	★★	81%	★★★
Coventry	87%	★★★	77%	★	70%	★	81%	★	74%	★
Kaiser Permanente	93%	★★★	93%	★★★	91%	★★★	89%	★★★	88%	★
M.D. IPA	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
OCI	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Family Medicine Physicians (see Table 129)

- The percentage of certified family medicine physicians ranged from 71–93 percent across plans, with two plans receiving N/R because they did not pass the audit for this measure. Two plans' rates were significantly higher than the Maryland average of 82 percent.

Table 129: Family Medicine Board-Certified Practitioners, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland HMO/ POS Average	**82%**	
Aetna	71%	★
BlueChoice	79%	★
CIGNA	81%	★★
Coventry	87%	★★★
Kaiser Permanente	93%	★★★
M.D. IPA	NR	NR
OCI	NR	NR

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- The *Family Medicine Physicians* and *Internal Medicine Physicians* measures replaced the *Board Certified Primary Care Practitioner Measure;* therefore, there is no trending.
- NR = This plan did not pass the audit for this measure.

Internal Medicine Physicians (see Table 130)

- In 2008, the rates of certified internal medicine physicians across plans ranged from 77–93 percent. Two plans' rates were significantly higher than the Maryland average of 82 percent.

Table 130: Internal Medicine Board-Certified practitioners, 2008 Results

	Comparison of Absolute Rates	Comparison of Relative Rates
Maryland HMO/ POS Average	**82%**	
Aetna	80%	★
BlueChoice	78%	★
CIGNA	83%	★★★
Coventry	77%	★
Kaiser Permanente	93%	★★★
M.D. IPA	NR	NR
OCI	NR	NR

Legend

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- The *Family Medicine Physicians* and *Internal Medicine Physicians* measures replaced the *Board Certified Primary Care Practitioner Measure;* therefore, there is no trending.
- NR = This plan did not pass the audit for this measure.

OB/GYN Practitioners (see Table 131)

- From 2006–2008, the average Maryland rate of certified OB/GYN practitioners decreased by 3 percentage points (from 79 percent to 76 percent). Three plans' rates decreased significantly over the two-year period.
- In 2008, plans' rates ranged from 68 percent–91 percent. One plan's rates were significantly higher than the Maryland average.

Table 131: OB/GYN Board Certification, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**79%**	**81%**	**76%**	**-3**			
Aetna	79%	78%	68%	🡻	★★	★	★
BlueChoice	76%	76%	75%	⇔	★	★	★★
CIGNA	85%	81%	76%	🡻	★★★	★★	★★
Coventry	77%	75%	70%	🡻	★★	★	★
Kaiser Permanente	89%	89%	91%	⇔	★★★	★★★	★★★
M.D. IPA	73%	84%	NR	--	★	★★★	NR
OCI	72%	83%	NR	--	★	★★★	NR

Legend

Change 2006–2008

🡹 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡻 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- NR = This plan did not pass the audit for this measure.

Pediatricians (see Table 132)

- From 2006–2008, the rate of Maryland board certified pediatricians increased from 78–84 percent. Two plans' rates increased significantly over the three-year period, while three plans showed no significant change.
- In 2008, rates ranged from 81–89 percent. One plan's rate was significantly higher and two plans' rates were significantly lower ratings than the Maryland average.

Table 132: Pediatric Specialist Board Certification, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**78%**	**71%**	**84%**	**5%**			
Aetna	70%	67%	83%	↑	★	★	★★
BlueChoice	83%	78%	81%	⇔	★★	★★★	★
CIGNA	72%	71%	85%	↑	★	★★	★★
Coventry	82%	72%	81%	⇔	★★	★★	★
Kaiser Permanente	79%	85%	89%	⇔	★★	★★	★★★
M.D. IPA	81%	63%	NR	--	★★	★	NR
OCI	81%	62%	NR	--	★★	★	NR

Legend

Change 2006–2008

↑ Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
↓ Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- NR = This plan did not pass the audit for this measure.

Other Practitioner Specialists (see Table 133)

- From 2006–2008, the rate of other practitioner specialists who are board certified in Maryland decreased by one percentage point. One plan's rate increased significantly over the two-year period, while three plans' rates decreased significantly.
- In 2008, plans' rates ranged from 71–88 percent. Two plans' rates were significantly higher and two plans' rates were significantly lower than the Maryland average.

Table 133: Other Specialist Board Certification, Trending

	Comparison of Absolute Rates				Comparison of Relative Rates		
	2006	2007	2008	Change 2006–2008	2006	2007	2008
Maryland HMO/POS Average	**80%**	**80%**	**79%**	**-1%**			
Aetna	74%	73%	71%	🡻	★	★	★
BlueChoice	81%	81%	NR	--	★★★	★★	NR
CIGNA	82%	80%	81%	🡻	★★★	★★	★★★
Coventry	84%	81%	74%	🡻	★★★	★★	★
Kaiser Permanente	85%	89%	88%	🡹	★★★	★★★	★★★
M.D. IPA	77%	79%	NR	--	★	★	NR
OCI	77%	79%	NR	--	★	★	NR

Legend

Change 2006–2008

🡹 Plan's actual (absolute) rate increased significantly from 2006–2008.
⇔ Plan's actual (absolute) rate *did not* change significantly from 2006–2008.
🡻 Plan's actual (absolute) rate decreased significantly from 2006–2008.

Relative Rates

★★★ = Individual plan rate significantly better than the Maryland HMO/POS average.
★★ = Individual plan rate equivalent to the Maryland HMO/POS average.
★ = Individual plan rate significantly worse than the Maryland HMO/POS average.

Notes

- NR = This plan did not pass the audit for this measure.

TOTAL ENROLLMENT

Background

Enrollment information conveys the size of the population that a health plan serves. Being aware of the size of each health plan may help interpret results presented in previous sections. Although quality and health plan size do not have a direct association, changes in enrollment size can have a measurable impact on member and provider satisfaction.

Member retention is an important issue for health plans. Health plans gain useful insight into the success of their programs using member opinion survey research as an indicator of plan quality. Feedback analysis can ultimately promote improvement in programs, which will also improve member retention. Factors that influence how members rate their plan include the quality of service provided by the plan, the quality of care provided by the plan's health care providers, and how much the plan costs the member.

Measure Definition

Enrollment by Product Line

The *Enrollment by Product Line* measure shows the aggregate number of member years contributed by members to the health plan during 2007. Member years are closely associated with the number of members in the health plan.

Enrollment by State

Enrollment by State is a second-year measure that shows the number of members enrolled any time during 2007, by state.

Summary of Changes to HEDIS 2008

There are no changes to this measure.

Notes

- For the *Enrollment by Product Line* measure, enrollment figures are for each plan's entire population, stratified by age and gender. Figures include Maryland residents and may include members residing in service areas of Washington, D.C., regions of Virginia, Delaware, southern New Jersey, southeastern Pennsylvania, and West Virginia, depending on the geographic configuration of the HMO.
- Enrollment figures for all plans except Kaiser Permanente include membership in HMO and POS products. Kaiser reports HEDIS rates based on the HMO product alone.

Results

Enrollment by Product Line (see Table 134)

- In 2008, the total enrollment for Maryland commercial HMO/POS plans by member years is estimated at 2.3 million, with the average plan enrollment size of approximately 325,000 members. This average enrollment size marks a decrease of about 16,000 members compared with 2007 enrollment.
- Plan membership ranged from 122,778–619,482 members. Two plans increased enrollment from 2007–2008.

Enrollment by State (see Table135)

- Maryland residents represent approximately 57 percent (1.35 million) of the members enrolled in the seven commercial HMO/POS operating in Maryland. The proportion of Maryland residents in each plan ranges from 24.7 percent–77.9 percent. Of the seven plans, BlueChoice has the largest percentage of Maryland members.

Table 134: Enrollment by Product Line (Member Years) in 2008

	Ages 0–19			Ages 20–44			Ages 45–64			Ages 65+			Total	Total
Maryland HMO/POS Average	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**2008**	**2007**
	46,839	**45,184**	**92,022**	**58,404**	**67,537**	**125,940**	**47,072**	**51,487**	**98,559**	**4,225**	**3,930**	**8,156**	**324,677**	**340,778**
Maryland Total	**327,870**	**316,286**	**644,156**	**408,825**	**472,757**	**881,582**	**329,506**	**360,408**	**689,914**	**29,578**	**27,511**	**57,089**	**2,272,741**	**2,385,448**
Aetna	47,117	45,737	92,854	51,779	69,034	114,813	39,857	45,037	84,894	4,031	3,951	7,982	300,543	308,030
BlueChoice	84,452	81,521	165,973	126,777	149,673	276,450	81,859	90,405	172,264	2,553	2,242	4,795	619,482	573,290
CIGNA	33,401	32,453	65,854	39,176	44,049	83,225	36,658	36,747	73,405	2,650	2,212	4,862	227,346	263,238
Coventry	16,164	15,229	31,393	24,552	22,868	47,420	19,806	19,495	39,301	2,510	2,154	4,664	122,778	132,527
Kaiser Permanente	64,108	61,753	125,861	75,839	90,898	166,737	67,867	79,405	147,272	7,469	7,168	14,637	454,507	447,198
M.D. IPA	33,231	31,860	65,091	27,380	34,901	62,281	32,065	36,221	68,286	5,176	4,959	10,135	206,793	224,016
OCI	49,397	47,733	97,130	63,322	67,334	130,656	51,394	53,098	104,492	5,189	4,825	10,014	342,292	437,149

Enrollment data for measurement years 2007 and 2006 are included for comparative purposes.

Table 135: Enrollment by State, 2008

	Maryland	Delaware	D.C.	New Jersey	Pennsylvania	Virginia	West Virginia	Other	Total
Maryland HMO/ POS Average	**57.26%**	**5.47%**	**4.24%**	**0.15%**	**1.40%**	**29.97%**	**0.97%**	**0.53%**	**100%**
Total State Enrollment	**1,350,736**	**47,284**	**112,511**	**1,633**	**23,672**	**651,472**	**19,863**	**13,627**	**2,221,608**
Aetna	58.35%	0.11%	7.24%	0.11%	0.52%	33.14%	0.21%	0.32%	294,184
BlueChoice	77.95%	0.23%	4.74%	0.02%	1.26%	14.56%	0.46%	0.80%	643,666
CIGNA	24.68%	0.04%	1.94%	0.06%	0.29%	70.20%	1.74%	1.03%	217,034
Coventry	58.97%	34.95%	0.05%	0.83%	4.80%	0.19%	0.05%	0.15%	106,128
Kaiser Permanente	51.57%	0.04%	8.93%	0.02%	0.26%	38.05%	0.34%	0.81%	454,425
M.D. IPA	65.09%	0.28%	4.65%	0.01%	0.89%	27.52%	1.18%	0.37%	202,141
OCI	64.24%	2.68%	2.12%	0.02%	1.76%	26.13%	2.81%	0.23%	304,030

COST AND EFFICIENCY

COST AND EFFICIENCY

Overview

Health plan quality measurement calls for dependable methods to fairly assess and compare how often members receive recommended care. Understanding health plan performance is incomplete without looking beyond rates of care and into the processes that health plans have in place to ensure that members access the care most beneficial to their health. This section features results gathered using the *eValue8* tool, which provides an in-depth analysis of plan processes to evaluate the system as a whole. This section also includes measures that cover relative resource use for members with specific chronic and acute conditions. Relative Resource Use Measures address the issue of health care quality when cost of care is taken into consideration.

Measures in Domain

- eValue8
- Relative Resource Use

MEASURING HEALTH CARE VALUE USING EVALUE8™

Background

Managed health care plans use various program practices to improve the quality of care provided and cost efficiency of services. These practices—which emphasize preventive care and disease management, wellness incentives, patient education, and utilization management (assessment of medical need)—form the system of programs that serve the plan's members, provider network, and organization. While the HEDIS quality measurement tool provides a snapshot of how often members receive recommended care, another tool uniquely designed to assess the key components of a health plan's system, *eValue8*, provides consumers with a better understanding about the role of the health plan and the effectiveness and efficiency of its programs. HEDIS, CAHPS, and *eValue8* are complementary tools for identifying and rewarding the best-performing health plans and enhancing the overall value of health plan selection for employers and consumers.

About *eValue8*

The *eValue8* tool is a product of the National Business Coalition on Health (NBCH), a national, non-profit, membership organization of nearly 70 employer-based health care coalitions, representing over 10,000 employers across the United States. The tool assesses health plans based on hundreds of established benchmarks in seven evaluation categories.

1. Prevention and Health Promotion
2. Chronic Disease Management
3. Consumer Engagement
4. Provider Measurement
5. Prescription Management
6. Behavioral Healthcare
7. Plan Profile

As part of a two-year pilot, MHCC has obtained the most current *eValue8* results from the Mid-Atlantic Business Group on Health (MABGH), the local affiliate of NBCH for Maryland employers. MABGH invited several major health plans in the region to submit information on their plan management and quality programs using the *eValue8* tool. Of those invited, three plans completed the tool in 2008: Aetna, BlueChoice, and Kaiser Permanente.

Measure Definition

Consumer Engagement

Assesses how the plan provides members with tools and strategies to support personal management of their health benefits. Examples include Web-based practitioner directories, electronic personal health records, and cost estimation tools for medical services and prescription drugs.

Preventive Care

Assesses availability and types of programs offered by the plan to screen for cancer, promote health education, and support healthier birth outcomes. HEDIS rates are included in the overall score as a measure of the effectiveness of immunization and cancer screening programs.

Disease Management

Assesses the breadth of the plan's disease management programs, with specific emphasis on diabetes and coronary artery disease (CAD). To determine the effectiveness of member and practitioner support programs, HEDIS rates for the two disease conditions are used to measure program performance.

Prescription Management

Assesses the plan's programs to manage and monitor issues of overuse, underuse, and misuse of prescription drugs. Examples include how the plan monitors and takes action on prescribing conflicts and manages the outpatient pharmacy network to ensure quality and safety.

Behavioral Health Care

Assesses the plan's programs for managing depression, screening for alcohol overuse, and other points in the provision of behavioral health services. HEDIS rates are included in the overall score as a measure of the effectiveness of programs to manage alcohol and depression.

Data Collection Methodology

Health plan programs are the source of *eValue8* data. Information was gathered from the health plan about its quality attainment programs, quality monitoring methods, and health system improvements.

Results *(see Table136)*

These results are based on an assessment of Aetna, BlueChoice, and Kaiser Permanente administrative processes and quality improvement programs.

- In 2008, Kaiser Permanente scored highest in four of the five measurement categories, followed by Aetna, which had the highest score for the one category presented in this section of the report. These high rates form the regional benchmarks for inter-plan performance comparison and plans' internal evaluation for further program development. Three of the regional benchmarks across the measurement categories increased between 2007 and 2008 while two regional benchmarks decreased during this past year.
- An assessment of methods to engage consumers in their health care showed a wide increase (30 percentage points) in the regional benchmark between 2007 and 2008. Although this rate increase is due to the 30 percentage point increase showed by Aetna, each plan saw an increased rate. Scores for this measure ranged from 40–84 percent. Implementation of member decision tools that aid in cost and quality determination will improve scores within this category. Examples include detailed practitioner information,

benefit designs that encourage use of hospitals that meet safety standards, and online ability to view claim status and progress toward deductible.

- For the second year, Kaiser Permanente scored better than other plans in monitoring the effectiveness of programs designed to address issues of overuse, underuse, and misuse of prescription drugs. Its score was 89 percent—9 percentage points less than the 2007 rate. With a rate of 50 percent, Aetna scored 8 percentage points higher than their rate in 2007. The score for this category emphasizes the plan's management of prescription drug use and efficiency. For example, plans that have high rates of generic drug use and have procedures for dose optimization (member takes fewer pills per day) will achieve higher scores in this category.
- Kaiser Permanente performed best in managing its members' behavioral health care, with a score of 84 percent—20 percentage points higher than its 2007 score. Aetna, which performed the best in 2007, decreased its rate from 77 percent in 2007 to 73 percent in 2008. BlueChoice scores were similar to Aetna's in 2008, with a score of 71 percent—6 percentage points higher than its 2007 score. Essential programs to score well within this category include those that focus on community collaboration, such as discussing use of common screening tools with other plans and plan support of practitioners.

Table 136: eValue8 Results

	Consumer Engagement		Preventive Care		Disease Management		Prescription Management		Behavioral Healthcare	
	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008
Regional Benchmark	**54%**	**84%**	**78%**	**90%**	**91%**	**83%**	**98%**	**89%**	**77%**	**84%**
Aetna	54%	84%	55%	57%	63%	60%	42%	50%	77%	73%
BlueChoice	38%	40%	57%	52%	71%	65%	54%	45%	65%	71%
Kaiser Permanente	50%	70%	78%	90%	91%	83%	98%	89%	64%	84%

Notes

- Scores are on a scale of 0–100%.
- For each regional benchmark, the highest score achieved for a measurement area represents the comparative standard with which to judge plan results.

RELATIVE RESOURCE USE MEASURES

Background

It has been estimated that in 2008, U.S. health care expenditures will account for an estimated 16.6 percent of U.S. spending, or $2.4 trillion (Kaiser Family Foundation, 2008).Controlling health care costs in the United States remains one of the top priority issues for policy makers, purchasers, and health plans. Between 2002 and 2007, the growth in health care premiums rose 78 percent, consistently outpacing wages and inflation, which rose 19 percent and 17 percent, respectively (Kaiser Family Foundation, 2007). As costs continue to escalate, affordability of health care becomes increasingly more significant.

NCQA developed six standardized Relative Resource Use (RRU) measures of health plans as part of the HEDIS measurement set. These measures focus on six high-cost conditions: diabetes, asthma, acute low back pain, cardiovascular conditions, uncomplicated hypertension, and COPD, which together account for 60 percent of private health care spending in the United States.

The populations included in the RRU measures represent eligible populations in current HEDIS quality measures; health care consumers can consider a plan's HEDIS quality and RRU measures together to obtain a better understanding of what they are getting for their purchase. Additionally, health plans and providers may find RRU and quality measure results useful for evaluating their own effectiveness at managing chronic illnesses and improving the health status of their members.

Measure Definitions

- The *Relative Resource Use for People With Diabetes* measure assesses the relative resource use for adult members with diabetes who were continuously enrolled during 2007.
- The *Relative Resource Use for People With Asthma* measure assesses the relative resource use for members with asthma who were continuously enrolled during 2007.
- The *Relative Resource Use for People With Acute Low Back Pain* measure assesses the relative resource use for members with a new diagnosis of low back pain during an acute low back pain episode treatment period.
- ***New measure in HEDIS 2008:*** The *Relative Resource Use for People With Cardiovascular Conditions* measure assesses the relative resource use for members with cardiovascular conditions during 2007.
- ***New measure in HEDIS 2008:*** The *Relative Resource use for People With Uncomplicated Hypertension* measure assesses the relative resource use by member with uncomplicated hypertension during 2007.
- ***New measure in HEDIS 2008:*** The *Relative Resources Use for People with COPD* measure assesses the relative resource use by members with chronic obstructive pulmonary disease (COPD) during 2007.

Calculating Results

Health plans use *Standardized Price Tables* to calculate and report total standardized costs and utilization rates across several health condition categories. NCQA calculates an expected (E) total standard cost for each chronic and acute condition by plan type (e.g., commercial) and product line (e.g., HMO). Resource use is adjusted for the composition of a plan's measure eligible population as it pertains to age, gender, and presence of comorbidities. This case-mix adjustment method allows comparisons of utilization performance, and thereby, eliminates the influences of factors such as having a large number of older members or members who have a greater burden of illness, which could have the effect of disadvantaging a plan in this type of assessment. Through this process, an expected cost is calculated for each health plan based on national norms after adjustments for the plan's mix of conditions and members. *Note this same method applies when calculating national and regional costs.*

Observed (O) amounts represent the plan's own experience. Health plans submit their cost or utilization data for each measure's eligible population by following HEDIS specifications, including applying the NCQA standardized prices to each unit of heath service included in the measures. Data are displayed as per member per month (PMPM) for the Cost Service categories.

Finally, NCQA calculates an RRU index based on standard costs, eligible members, and services that serves as the basis for developing the O/E Ratio. The O/E Ratio shows health plan results as compared to the average national or regional eligible population. For example, for the clinical condition of diabetes a ratio result of 1.00 indicates that a health plan spent or used the same level of resources in treating its population as the average used to treat all eligible members with a given condition. A ratio of 1.12 indicates that a health plan used 12 percent more resources than the national average; and a ratio of 0.73 indicates that a plan used 27 percent fewer resources than average. *Note that the results tables that follow provide expected standard costs calculated for as a representation of the average operating national plan or regional plan. The O/E Ratio for the nation (or region) reflects the resource experience across all plans submitting data in relation to the expected costs for the eligible population.*

Results for RRU

In 2008, RRU data is reported at the national and regional level. Regional level data included in this report are from The U.S. Department of Health and Human Services Region 3 - Philadelphia: Maryland, Delaware, Pennsylvania, Virginia, West Virginia, and the District of Columbia. NCQA has also taken the position to not publicly report plan-level reporting data because these measures require further analysis before definitive conclusions can be made.

NCQA's 2008 *State of Health Care Quality* report presented findings from an examination of quality and associated resource use for people with diabetes enrolled in commercial HMO and point-of-service plans. Data suggest that little to no meaningful relationship exists between the quality of care a plan delivers to diabetics and the resources it uses to deliver that care (similar to 2007 results). In other words, some plans deliver relatively high-quality care and use relatively few resources, while other plans deliver relatively low-quality care and use more resources than average. The report concludes that these data point to inefficiency in the health care system. They demonstrate that getting the *most* care does not necessarily equate to getting the *best* care.

These results hold true for all RRU measures, plans have shown a wide variability between costs and quality. By finding common factors among plans that deliver high-quality care at low cost, it may be possible to reduce resource use without sacrificing quality.

RRU for People With Diabetes (see Table 137)

- In 2008, for people with diabetes the expected medical cost average was $243.71 (national) and the expected regional average medical cost was $261.22. Nationally, plans spent 7 percent more resources than the expected national average. Regionally, the ratio of 1.05 indicates that health plans used 5 percent more resources than the expected regional average.
- In 2008, for people with diabetes the expected national pharmacy cost average was $214.31 and the expected regional average pharmacy cost was $215.09. Nationally, plans used 2 percent more than the expected national average and regionally plans spent 3 percent more than the expected regional average.

Table 137: Relative Resource use for People With Diabetes, 2008 Results

		N	Mean	P10	P90
National Total Medical	**Expected**	206	$243.71	$220.12	$267.58
	Ratio Results O/E	201	1.07	0.73	1.37
Regional Total Medical	**Expected**	25	$261.22	$235.41	$279.52
	Ratio Results O/E	24	1.05	0.82	1.27
National Total Pharmacy	**Expected**	206	$214.31	$199.66	$227.13
	Ratio Results O/E	206	1.02	0.77	1.20
Regional Total Pharmacy	**Expected**	25	$215.09	$7.86	$224.10
	Ratio Results O/E	25	1.03	0.26	1.37

Legend
N= Number of HMO/POS plans reporting
P10= Tenth percentile
P90= Ninetieth percentile
O/E= Observed/Expected

Notes
- Regional data include Maryland, Delaware, Pennsylvania, West Virginia, Virginia, and the District of Columbia.
- "N" differs for the *expected* and *ratio results* because although a given number of plans submitted data used in calculating the expected value for a condition, those plans may not have submitted data for the full combination of service categories. Only those plans submitting data for all service categories for the selected condition were included when determining *observed to expected ratio results.*
- Ratio Results Observed-to-Expected (O/E) = the plan submitted (observed) data divided by the NCQA risk adjusted (expected) data.

RRU for People With Asthma (see Table 138)

- In 2008, for people with asthma, the expected total medical cost nationally was $109.45 and the expected total regional cost as $121.52. Nationally, plans used 10 percent more resources than expected and regionally, plans used 3 percent more resources than expected.
- In 2008, nationally, plans used only one percent more resources than the expected national total pharmacy cost. Regionally, plans used 2 percent fewer resources than expected.

Table 138: Relative Resource Use for People With Asthma, 2008 Results

		N	Mean	P10	P90
National Total Medical	**Expected**	229	$109.45	$100.02	$120.46
	Ratio Results O/E	224	1.10	0.79	1.39
Regional Total Medical	**Expected**	26	$121.53	$105.59	$140.38
	Ratio Results O/E	25	1.03	0.75	1.25
National Total Pharmacy	**Expected**	229	$166.19	$154.03	$179.61
	Ratio Results O/E	229	1.01	0.78	1.17
Regional Total Pharmacy	**Expected**	26	$179.55	$164.54	$199.24
	Ratio Results O/E	26	0.98	0.72	1.43

Legend
N= Number of HMO/POS plans reporting
P10= Tenth percentile
P90= Ninetieth percentile
O/E= Observed/Expected

Notes
- Regional data include Maryland, Delaware, Pennsylvania, West Virginia, Virginia, and the District of Columbia.
- "N" differs for the *expected* and *ratio results* because although a given number of plans submitted data used in calculating the expected value for a condition, those plans may not have submitted data for the full combination of service categories. Only those plans submitting data for all service categories for the selected condition were included when determining *observed to expected ratio results.*
- Ratio Results Observed-to-Expected (O/E) = the plan submitted (observed) data divided by the NCQA risk adjusted (expected) data.

RRU for People With Low Back Pain (see Table 139)

- In 2008, the national total expected medical cost for people with low back pain was $62.52 and the regional total medical expected cost was $41.50. Plans used 33 percent more resources than expected at the national level, and more than double the resources 79 percent more resources than expected on the regional level.
- The average expected national total pharmacy cost in 2008 was $25.80 for people with low back pain and the expected regional total pharmacy cost was $10.21.

Table 139: Relative Resource Use for People With Low Back Pain, 2008 Results

		N	Mean	P10	P90
National Total Medical	**Expected**	226	$62.52	$220.12	$267.58
	Ratio Results O/E	221	1.33	0.89	1.82
Regional Total Medical	**Expected**	26	$41.50	$41.04	$41.91
	Ratio Results O/E	25	1.79	0.31	2.68
National Total Pharmacy	**Expected**	226	$25.80	$25.23	$26.37
	Ratio Results O/E	226	0.82	0.28	0.85
Regional Total Pharmacy	**Expected**	26	$10.21	$10.02	$10.37
	Ratio Results O/E	26	2.12	0.71	5.17

Legend
N= Number of HMO/POS plans reporting
P10= Tenth percentile
P90= Ninetieth percentile
O/E= Observed/Expected

Notes
- Regional data include Maryland, Delaware, Pennsylvania, West Virginia, Virginia, and the District of Columbia.
- "N" differs for the *expected* and *ratio results* because although a given number of plans submitted data used in calculating the expected value for a condition, those plans may not have submitted data for the full combination of service categories. Only those plans submitting data for all service categories for the selected condition were included when determining *observed to expected ratio results.*
- Ratio Results Observed-to-Expected (O/E) = the plan submitted (observed) data divided by the NCQA risk adjusted (expected) data.

RRU for People with Cardiovascular Conditions (see Table 140)

- The average expected national total medical cost in 2008 was $524.83 for people with cardiovascular conditions and the average expected regional total medical cost was $529.04. Nationally, plans use 3 percent more resources than expected. Regionally, plans used 1 percent fewer resources than expected.
- In 2008, the national total expected pharmacy cost for people with cardiovascular conditions was $241.68 and the regional total expected pharmacy cost was $240.65. Nationally, plans used the same amount of resources as expected with a ratio of 1.00. Regionally, plans used 4 percent more resources than expected.

Table 140: Relative Resource Use for People With Cardiovascular Conditions, 2008 Results

		N	Mean	P10	P90
National Total Medical	**Expected**	199	$524.83	$490.30	$557.98
	Ratio Results O/E	194	1.03	0.68	1.36
Regional Total Medical	**Expected**	23	$529.04	$490.08	$585.20
	Ratio Results O/E	22	0.99	0.70	1.33
National Total Pharmacy	**Expected**	199	$241.68	$227.69	$253.38
	Ratio Results O/E	199	1.00	0.71	1.18
Regional Total Pharmacy	**Expected**	23	$240.65	$231.86	$251.32
	Ratio Results O/E	23	1.04	0.82	1.46

Legend
N= Number of HMO/POS plans reporting
P10= Tenth percentile
P90= Ninetieth percentile
O/E= Observed/Expected

Notes
- Regional data include Maryland, Delaware, Pennsylvania, West Virginia, Virginia, and the District of Columbia.
- "N" differs for the *expected* and *ratio results* because although a given number of plans submitted data used in calculating the expected value for a condition, those plans may not have submitted data for the full combination of service categories. Only those plans submitting data for all service categories for the selected condition were included when determining *observed to expected ratio results.*
- Ratio Results Observed-to-Expected (O/E) = the plan submitted (observed) data divided by the NCQA risk adjusted (expected) data

RRU for People With Uncomplicated Hypertension (see Table 141)

- The average expected national total medical cost in 2008 was $158.54 for people with uncomplicated hypertension and the average expected regional total medical cost was $162.36. Nationally, plans used 10 percent more resources than the national expected average; while regionally plans used only 1 percent more resources than the regional expected average.
- In 2008, the national total expected pharmacy cost for people with uncomplicated hypertension was $113.47 and the regional total expected pharmacy cost was $116.13. On average, regional plans used the same amount of resources as expected; while nationally, plans used 7 percent less resources than expected.

Table 141: Relative Resource Use for People With Uncomplicated Hypertension, 2008 Results

		N	Mean	P10	P90
National Total Medical	**Expected**	219	$158.54	$154.24	$162.68
	Ratio Results O/E	214	1.10	0.83	1.37
Regional Total Medical	**Expected**	26	$162.36	$159.85	$164.45
	Ratio Results O/E	25	1.01	0.79	1.24
National Total Pharmacy	**Expected**	219	$113.47	$108.77	$118.22
	Ratio Results O/E	219	0.93	0.72	1.09
Regional Total Pharmacy	**Expected**	26	$116.13	$113.44	$118.67
	Ratio Results O/E	26	1.00	0.73	1.83

Legend
N= Number of HMO/POS plans reporting
P10= Tenth percentile
P90= Ninetieth percentile
O/E= Observed/Expected

Notes
- Regional data include Maryland, Delaware, Pennsylvania, West Virginia, Virginia, and the District of Columbia.
- "N" differs for the *expected* and *ratio results* because although a given number of plans submitted data used in calculating the expected value for a condition, those plans may not have submitted data for the full combination of service categories. Only those plans submitting data for all service categories for the selected condition were included when determining *observed to expected ratio results.*
- Ratio Results Observed-to-Expected (O/E) = the plan submitted (observed) data divided by the NCQA risk adjusted (expected) data.

RRU for People with COPD (see Table 142)

- In 2008, the national total expected medical cost was $507.20 for people with COPD. The regional expected medical cost was $558.17. Both regionally and nationally plans used nearly the same amount of resources as expected with resource use only one percent above or below the expected levels regionally and nationally.
- The average national expected total pharmacy cost in 2008 was $201.58, with a 1.00 ratio. Regional total average cost was $195.42; 6 percent less than the expected regional cost.

Table 142: Relative Resource Use for People With COPD, 2008 Results

		N	Mean	P10	P90
National Total Medical	**Expected**	226	$507.20	$466.61	$556.59
	Ratio Results O/E	221	1.01	0.68	1.28
Regional Total Medical	**Expected**	26	$558.17	$507.36	$609.42
	Ratio Results O/E	25	0.99	0.77	1.22
National Total Pharmacy	**Expected**	226	$201.58	$188.41	$218.24
	Ratio Results O/E	226	1.00	0.72	1.20
Regional Total Pharmacy	**Expected**	26	$195.42	$177.32	$212.78
	Ratio Results O/E	26	0.94	0.72	1.16

Legend
N= Number of HMO/POS plans reporting
P10= Tenth percentile
P90= Ninetieth percentile
O/E= Observed/Expected

Notes
- Regional data include Maryland, Delaware, Pennsylvania, West Virginia, Virginia, and the District of Columbia.
- "N" differs for the *expected* and *ratio results* because although a given number of plans submitted data used in calculating the expected value for a condition, those plans may not have submitted data for the full combination of service categories. Only those plans submitting data for all service categories for the selected condition were included when determining *observed to expected ratio results.*
- Ratio Results Observed-to-Expected (O/E) = the plan submitted (observed) data divided by the NCQA risk adjusted (expected) data.

EXTERNAL ACCREDITATION

EXTERNAL ACCREDITATION

Overview

Accreditation is another way of assessing health plan quality; it is an independent, external assessment of quality by a review organization. NCQA and URAC accredit the health plans and MBHOs in this report.

Each health care organization in this report voluntarily obtained NCQA Accreditation or URAC Accreditation (or both). In Maryland, accreditation is not required for health plans or MBHOs.

HEALTH PLAN ACCREDITATION

Table 143 identifies the accreditation status of each Maryland health plan and identifies the accrediting organization.

Table 143: Health Plan Accreditation Status

Health Plan	Accreditation*		
	Organization	Status	Expiration
Aetna	NCQA	Excellent	December 2011
Aetna PPO	NCQA	Full	December 2010
BlueChoice	NCQA	Excellent	November 2010
BluePreferred PPO	NCQA	Full	November 2010
CIGNA	NCQA	Excellent	September 2009
CGLIC	NCQA	Full	December 2010
Coventry	URAC	Full Accreditation	June 2010
Kaiser Permanente	NCQA	Excellent	June 2010
M.D. IPA	NCQA	Commendable	March 2009
OCI	NCQA	Commendable	March 2009
MAMSI Life PPO	—	—	—

*Accreditation status as of September 2008.

NCQA Health Plan Accreditation

NCQA Accreditation evaluates how well a health plan manages its delivery system—physicians, hospitals, other providers, and administrative services—for continuous improvement of its members' health care. A team of physicians and managed care experts conducts onsite and offsite evaluations. The team reviews grievance procedures, physician evaluation, and care management processes; preventive health efforts; medical record keeping; quality improvement; and performance on key aspects of clinical care, such as immunization rates. In 2008, NCQA's Accreditation program required plans to report performance results for 17 clinical care and 9 satisfaction measures.

A national Review Oversight Committee (ROC) of physicians analyzes the team's findings and assigns an accreditation level based on a plan's performance on selected HEDIS measures, relative to NCQA standards and to other plans. The standards and performance measures that make up NCQA's accreditation program fall into the following categories: Access and Service, Qualified Providers, Staying Healthy, Getting Better, and Living With Illness.

NCQA Accreditation Levels

NCQA assigns one of five possible accreditation levels based on a plan's performance.

- ***Excellent (for HMOs and POS plans):*** Highest accreditation status awarded to plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement. Plans earning this accreditation level achieve HEDIS results in the highest range of national or regional performance.

- ***Full (for PPOs):*** Highest accreditation status awarded to PPOs whose programs for quality improvement and consumer protection exceed NCQA's standards.
- ***Commendable:*** Awarded to plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's requirements for quality improvement and consumer protection.
- ***One-Year (for PPOs):*** Awarded to PPO plans that have well-established programs for quality improvement and consumer protection and meet most NCQA standards. NCQA provides recommendations and reviews the organization after a year to determine if it qualifies for Full Accreditation.
- ***Accredited:*** Awarded to health plans that meet most of NCQA's basic requirements for consumer protection and quality improvement.
- ***Provisional:*** Awarded to health plans that meet some, but not all, of NCQA's basic requirements for consumer protection and quality improvement.
- ***Denied:*** Indicates that a health plan did not meet NCQA's requirements.

Note

- In 2008, NCQA introduced Health Plan Accreditation, which surveys health plans of all types, including HMO/POS and PPO plans, on the same set of requirements. With this new program, NCQA stopped accepting applications for the HMO/POS and PPO Accreditation programs, but because NCQA Accreditation is valid for up to three years, many health plans still hold HMO/POS or PPO Accreditation.

Pharmacy Management Standards

Maryland HMO/POS plans accredited by NCQA have met NCQA standards for pharmaceutical management, including formulary development. To help ensure that plan drug formularies are fair and valid, formulary policies are reviewed under the pharmaceutical management standards for HMO/POS plans that choose NCQA Accreditation. NCQA standards require a plan's formulary to meet the following criteria.

- The formulary is based on sound clinical evidence
- There is annual review of the formulary, with updates at least annually
- There is involvement of appropriate, actively practicing practitioners, including pharmacists, in the development and updating of the formulary
- There is a policy of giving practitioners a copy of the formulary and notifying them of changes
- There are policies that consider medically necessary exceptions to the formulary

The following health plans are accredited by NCQA and have met the pharmaceutical management standards described above: Aetna, BlueChoice, CIGNA, Kaiser Permanente, M.D. IPA, and OCI.

URAC Health Plan Accreditation

URAC Health Plan Accreditation standards provide a comprehensive assessment of health plan performance and apply to health care systems such as HMOs and fully integrated PPOs that provide a full range of health care services. Standards include key quality benchmarks for network management, provider credentialing, utilization and quality management, improvement, and consumer protection.

Organizations applying for accreditation participate in a review process involving several phases. The initial phase consists of completing the application forms and supplying supporting documentation. The remaining three phases of the accreditation process cover a period of approximately three to six months.

- ***Desktop Review:*** The reviewer conducts an analysis of the applicant's documentation with regard to URAC standards.
- ***Onsite Review:*** The accreditation review team conducts this review after it completes the Desktop Review, to verify compliance with the standards.
- ***Committee Review:*** The last phase of review, leading to a recommendation regarding the application, involves examination by two URAC committees that comprise professionals from health care and other industry experts.

Following these reviews, an accreditation recommendation is provided to URAC's Executive Committee, which makes the final decision.

URAC Accreditation Levels

URAC assigns health plans one of three possible accreditation levels based on performance.

- ***Full:*** Awarded to organizations that successfully meet all requirements. Full Accreditation is for two years. An accreditation certificate is issued to each company site that participates in the accreditation review. As a condition of accreditation, organizations must remain compliant with URAC standards during the two-year accreditation cycle
- ***Conditional:*** Awarded to organizations that have appropriate documentation but did not completely implement certain policies or procedures before achieving full compliance. Organizations must follow a plan to demonstrate full compliance and move to Full Accreditation status within six months.
- ***Provisional:*** Awarded to organizations that complied with all standards but had not been in operation long enough (less than six months) at the time of the onsite review to demonstrate full compliance. Organizations must demonstrate full compliance of standards to meet Full Accreditation status.

Organizations unable to meet URAC standards may be placed on corrective action status, may be denied accreditation, or may withdraw from the application process.

MBHO ACCREDITATION

Like health plans, MBHOs can apply for voluntary accreditation. Accreditation indicates that the MBHO has met the quality standards set by the accrediting organization. Maryland plans in this report are participating in NCQA Accreditation or URAC Accreditation, or both.

Table 144 shows which plans use MBHOs to cover some or all of their members. The table also indicates each MBHO's accreditation status, the accrediting organization, and when current accreditation expires. Two plans provide behavioral health services through their own provider network. Behavioral health services for these plans are not accredited separately from the health plan's accreditation.

Table 144: MBHO Accreditation Status and Behavioral Health Benefit

Health Plan	MBHO	Accrediting Body*	Status and Expiration Date	Percentage of Members With Behavioral Health Benefit
Aetna	Aetna Behavioral Health	NCQA	*Full:* January 2011	99.35%
BlueChoice	Magellan Tristate Care Management Center	NCQA URAC	*Full:* May 2009 *Full:* June 2010	100%
CIGNA	CIGNA Behavioral Health—Chesapeake	NCQA URAC	*Full:* December 2009 *Full:* November 2009	70.31%
Coventry	United Behavioral Health-Atlanta	NCQA URAC	*Full:* December 2010 *Full: February* 2010	96.32%
Kaiser Permanente**	APS	URAC	*Full:* November 2010	100%
M.D. IPA	United Behavioral Health-Philadelphia	NCQA URAC	*Full:* June 2010 *Full:* February 2010	85.52%
OCI	United Behavioral Health-Philadelphia	NCQA URAC	*Full:* June 2010 *Full:* February 2010	99.63%

* Accreditation is voluntary. Accreditation status as of July 2008.

** During 2006, Kaiser Permanente transitioned to an in-house network of behavioral health providers for members, except in the Baltimore area. For further details, contact Kaiser Permanente.

Visit www.ncqa.org and www.urac.org for the most current information on accreditation status.

NCQA MBHO Accreditation

NCQA's MCO and MBHO accreditation programs are closely aligned with nearly identical sets of standards that apply to both types of organization. Both programs seek to promote access to behavioral healthcare and coordination between medical and behavioral health professionals.

The MBHO Accreditation Program requires an MBHO to annually monitor and evaluate at least two preventive behavioral health screening and educational interventions offered to its covered population. The categories of preventive interventions listed in the standard are adapted from the Institute of Medicine's *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research,* 1994. This publication lists a number of illustrative preventive interventions for the various age and population categories.

URAC MBHO Accreditation

Like other integrated health care delivery systems, MBHOs may undergo a full review of their operations or have individual components reviewed for accreditation. The Health Utilization Management Standards are an example of an accreditation module that MCOs (such as MBHOs) select to demonstrate that they have the appropriate structures and procedures to promote quality care when making medical necessity determinations. URAC's Health Plan Standards Program assesses an organization and assigns an accreditation level based on performance regarding defined standards. This process consists of the same multiphase review described previously for Health Plan Accreditation.

APPENDIX A:
HEALTH PLAN PERFORMANCE BY MEASURE

HEALTH PLAN PERFORMANCE BY MEASURE

This appendix contains plan results sorted by plan rates for selected measures to show which plans performed best in each category of care. Measures were based on the eligible measures included in the above-average score calculation described in the *Summary of Performance*.

Effectiveness of Care
Plan Performance by Measure
(HMO/POS)

Childhood Immunization Status Combination 3, 2008 Results		
Maryland HMO/POS Average	**77%**	
CIGNA	82%	★★★
Kaiser Permanente	81%	★★
Aetna	77%	★★
Coventry	76%	★★
M.D. IPA	76%	★★
OCI	76%	★★
BlueChoice	73%	★

Childhood Immunization Status Combination 2, 2008 Results		
Maryland HMO/POS Average	**83%**	
CIGNA	87%	★★★
Kaiser Permanente	86%	★★
Aetna	85%	★★
BlueChoice	82%	★★
M.D. IPA	82%	★★
Coventry	81%	★★
OCI	81%	★★

Appropriate Testing for Children with Pharyngitis, 2008 Results		
Maryland HMO/POS Average	**82%**	
Kaiser Permanente	92%	★★★
CIGNA	83%	★★★
Aetna	81%	★★
BlueChoice	80%	★
M.D. IPA	80%	★
OCI	80%	★
Coventry	76%	★

Appropriate Treatment for Children with Upper Respiratory Infection, 2008 Results		
Maryland HMO/POS Average	**85%**	
Kaiser Permanente	93%	★★★
Aetna	87%	★★★
CIGNA	86%	★★★
Coventry	86%	★
M.D. IPA	84%	★★
OCI	83%	★
BlueChoice	81%	★

Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis, 2008 Results		
Maryland HMO/POS Average	**28%**	
Kaiser Permanente	56%	★★★
BlueChoice	26%	★
Aetna	25%	★
CIGNA	24%	★
OCI	24%	★
Coventry	22%	★
M.D. IPA	21%	★

Use of Spirometry Testing in the Assessment and Diagnosis of COPD, 2008 Results		
Maryland HMO/POS Average	**36%**	
CIGNA	39%	★★
Aetna	37%	★★
Kaiser Permanente	36%	★★
M.D. IPA	36%	★★
OCI	36%	★★
BlueChoice	35%	★★
Coventry	33%	★★

Effectiveness of Care
Plan Performance by Measure
(HMO/POS)

Use of Appropriate Medications for People With Asthma (Combined Age Groups), 2008 Results		
Maryland HMO/POS Average	**94%**	
Kaiser Permanente	96%	★★★
Coventry	94%	★★
OCI	94%	★★
Aetna	93%	★★
BlueChoice	93%	★
CIGNA	93%	★★
M.D. IPA	93%	★★

Colorectal Cancer Screening, 2008 Results		
Maryland HMO/POS Average	**58%**	
CIGNA	68%	★★★
Kaiser Permanente[m]	61%	★★★
M.D. IPA[m, r]	61%	★★
BlueChoice	58%	★★
OCI[m, r]	56%	★★
Aetna	56%	★
Coventry[m]	45%	★

Breast Cancer Screening, 2008 Results		
Maryland HMO/POS Average	**68%**	
Kaiser Permanente	75%	★★★
CIGNA	68%	★★
Coventry	68%	★★
M.D. IPA	68%	★★
BlueChoice	65%	★
Aetna	66%	★
OCI	64%	★

Cervical Cancer Screening, 2008 Results		
Maryland HMO/POS Average	**82%**	
CIGNA	84%	★★
BlueChoice[m]	83%	★★
M.D. IPA[r]	83%	★★
Kaiser Permanente[m]	82%	★★
Coventry[r]	80%	★★
Aetna[r, m]	79%	★
OCI[r, m]	78%	★

Chlamydia Screening Total (Ages 16-25), 2008 Results		
Maryland HMO/POS Average	**43%**	
Kaiser Permanente	71%	★★★
BlueChoice	43%	★★
CIGNA	40%	★
Coventry	40%	★
Aetna	39%	★
M.D. IPA	37%	★
OCI	35%	★

Controlling High Blood Pressure, 2008 Results		
Maryland HMO/POS Average	**63%**	
CIGNA	76%	★★★
BlueChoice[r]	68%	★★★
Kaiser Permanente	65%	★★★
Coventry[r]	61%	★
Aetna	60%	★
OCI[r]	57%	★
M.D. IPA	54%	★

Effectiveness of Care
Plan Performance by Measure
(HMO/POS)

Persistence of Beta-Blocker Treatment After a Heart Attack, 2008 Results		
Maryland HMO/POS Average	**73%**	
Coventry	78%	★★
M.D. IPA	78%	★★
Kaiser Permanente	76%	★★
OCI	76%	★★
BlueChoice	71%	★★
CIGNA	67%	★★
Aetna	66%	★

Cholesterol Management, LDL-C Screening, 2008 Results		
Maryland HMO/POS Average	**85%**	
CIGNA	92%	★★★
Kaiser Permanente	88%	★★
M.D. IPA	85%	★★
OCI	84%	★★
Aetna	83%	★★
Coventry	82%	★★
BlueChoice	81%	★

Cholesterol Management, LDL-C <100 mg/dL, 2008 Results		
Maryland HMO/POS Average	**58%**	
CIGNA	68%	★★★
Kaiser Permanente[m]	62%	★★
OCI	60%	★★
M.D. IPA	58%	★★
Coventry	56%	★★
Aetna	54%	★★
BlueChoice	46%	★

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Testing, 2008 Results		
Maryland HMO/POS Average	**85%**	
CIGNA	93%	★★★
Coventry	85%	★★
Aetna	84%	★★
BlueChoice	84%	★★
Kaiser Permenente	83%	★★
M.D. IPA	83%	★★
OCI	83%	★★

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Control, 2008 Results		
Maryland HMO/POS Average	**70%**	
CIGNA	78%	★★★
BlueChoice	77%	★★★
OCI	69%	★★
M.D. IPA	68%	★★
Aetna	67%	★★
Coventry	67%	★★
Kaiser Permanente	65%	★

Comprehensive Diabetes Care, Cholesterol (LDL-C) Testing, 2008 Results		
Maryland HMO/POS Average	**83%**	
CIGNA	90%	★★★
Coventry	83%	★★
Aetna	82%	★★
BlueChoice	82%	★★
Kaiser Permanente	81%	★★
M.D. IPA	81%	★★
OCI	79%	★★

Effectiveness of Care
Plan Performance by Measure
(HMO/POS)

Comprehensive Diabetes Care, Cholesterol (LDL-C) <100mg/dL Control, 2008 Results		
Maryland HMO/POS Average	**46%**	
BlueChoice	65%	★★★
CIGNA	47%	★★
Coventry	45%	★★
Aetna	43%	★★
Kaiser Permanente	41%	★
M.D. IPA	41%	★
OCI	41%	★

Comprehensive Diabetes Care, Eye Exams, 2008 Results		
Maryland HMO/POS Average	**56%**	
M.D. IPA	64%	★★★
Kaiser Permanente[m]	63%	★★★
Aetna	58%	★★
CIGNA	58%	★★
OCI	51%	★
Coventry	49%	★
BlueChoice	48%	★

Comprehensive Diabetes Care, Medical Attention for Diabetic Nephropathy, 2008 Results		
Maryland HMO/POS Average	**80%**	
Kaiser Permanente	91%	★★★
CIGNA	83%	★★
Coventry	82%	★★
Aetna	80%	★★
M.D. IPA	77%	★★
OCI	76%	★
BlueChoice	73%	★

Comprehensive Diabetes Care, Blood Pressure Control <130/80 mm Hg, 2008 Results		
Maryland HMO/POS Average	**30%**	
CIGNA	41%	★★★
BlueChoice	40%	★★★
Kaiser Permanente	34%	★★★
Aetna	25%	★
Coventry	25%	★
OCI	25%	★
M.D. IPA	20%	★

Comprehensive Diabetes Care, Blood Pressure Control <140/90 mm Hg, 2008 Results		
Maryland HMO/POS Average	**59%**	
CIGNA	76%	★★★
Kaiser Permanente	63%	★★★
Coventry	58%	★★
BlueChoice	57%	★★
Aetna	54%	★★
OCI	52%	★
M.D. IPA	51%	★

Comprehensive Diabetes Care MHCC-Specific Combination Rating, 2008 Results		
Maryland HMO/POS Average	**10%**	
BlueChoice	13%	★★★
CIGNA	13%	★★
Coventry	10%	★★
M.D. IPA	10%	★★
Kaiser Permanente	9%	★★
Aetna	8%	★★
OCI	7%	★

Effectiveness of Care
Plan Performance by Measure
(HMO/POS)

Flu Shots for Adults Ages 50-64, 2008 Results		
Maryland HMO/POS Average	**49%**	
Kaiser Permanente	57%	★★★
M.D. IPA	52%	★★
CIGNA	52%	★★
Coventry	47%	★★
Aetna	46%	★★
OCI	44%	★★
BlueChoice	43%	★

Medical Assistance with Smoking Cessation -Advising Smokers to Quit, 2008 Results		
Maryland HMO/POS Average	**78%**	
BlueChoice	80%	★★
Coventry	76%	★★
Kaiser Permanente	.	★
Aetna	.	NA
CIGNA	.	NA
M.D. IPA	.	NA
OCI	.	NA

Medical Assistance with Smoking Cessation -Discussing Smoking Cessation Medications, 2008 Results		
Maryland HMO/POS Average	**47%**	
BlueChoice	48%	★★
Coventry	47%	★★
CIGNA	NA	★
Aetna	NA	NA
Kaiser Permanente	NA	NA
M.D. IPA	NA	NA
OCI	NA	NA

Medical Assistance with Smoking Cessation -Discussing Smoking Cessation Strategies, 2008 Results		
Maryland HMO/POS Average	**47%**	
BlueChoice	48%	★★
Coventry	46%	★★
Aetna	NA	NA
CIGNA	NA	NA
Kaiser Permanente	NA	NA
M.D. IPA	NA	NA
OCI	NA	NA

Disease Modifying Anti-Rheumatic Therapy in Rheumatoid Arthritis, 2008 Results		
Maryland HMO/POS Average	**84%**	
M.D. IPA	89%	★★★
Coventry	89%	★★
CIGNA	87%	★★
Kaiser Permanente	85%	★★
BlueChoice	81%	★
Aetna	80%	★
OCI	80%	★

Annual Monitoring for Patients on Persistent Medication, 2008 Results		
Maryland HMO/POS Average	**78%**	
BlueChoice	81%	★★★
CIGNA	80%	★★★
Aetna	79%	★★★
M.D. IPA	79%	★★★
OCI	77%	★
Coventry	75%	★
Kaiser Permanente	75%	★

Effectiveness of Care
Plan Performance by Measure
(PPO)

Appropriate Testing for Children With Pharyngitis, 2008 Results		
Maryland PPO Average	**83%**	
MAMSI Life	84%	★★
CGLIC	83%	★★
Aetna PPO	82%	★★
Blue Preferred	81%	★★

Appropriate Testing for Children With Upper Respiratory Infection, 2008 Results		
Maryland PPO Average	**85%**	
Aetna PPO	89%	★★★
CGLIC	86%	★★
Blue Preferred	83%	★
MAMSI Life	83%	★

Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis, 2008 Results		
Maryland PPO Average	**29%**	
Aetna PPO	42%	★★★
CGLIC	28%	★★
BluePreferred	26%	★
MAMSI Life	20%	★

Use of Appropriate Medications for People With Asthma (Combined Age Groups)		
Maryland PPO Average	**94%**	
Blue Preferred	95%	★★★
CGLIC	94%	★★
Aetna PPO	93%	★★
MAMSI Life	93%	★★

Breast Cancer Screening, 2008 Results		
Maryland PPO Average	**63%**	
MAMSI Life	66%	★★★
Aetna PPO	65%	★★★
CGLIC	63%	★★
Blue Preferred	58%	★

Persistence of Beta-Blocker Treatment After a Heart Attack, 2008 Results		
Maryland PPO Average	**71%**	
MAMSI Life	85%	★★★
CGLIC	74%	★★
Blue Preferred	68%	★★
Aetna PPO	59%	★

Access/Availability of Care
Plan Performance by Measure
(HMO/POS)

Well-Child Visits for Infants and Children (Composite), 2008 Results		
Maryland HMO/POS Average	**76%**	
M.D. IPA	79%	★★★
CIGNA[m]	78%	★★★
BlueChoice[m]	76%	★★
Coventry[m]	76%	★★
Kaiser Permanente[m]	75%	★
OCI	76%	★★
Aetna[m]	69%	★

Adolescent Well-Care Visits, 2008 Results		
Maryland HMO/POS Average	**44%**	
Aetna[m]	43%	★
BlueChoice[m]	45%	★★
CIGNA[m]	44%	★★
Coventry[m]	44%	★★
Kaiser Permanente[m]	42%	★
M.D. IPA	45%	★★
OCI	48%	★★

Prenatal and Postpartum Care, Prenatal Care, 2008 Results		
Maryland HMO/POS Average	**93%**	
CIGNA	98%	★★★
Aetna	96%	★★★
BlueChoice	94%	★★
Kaiser Permanente	94%	★★
Coventry	92%	★★
OCI	91%	★★
M.D. IPA	87%	★

Prenatal and Postpartum Care, Postpartum Care, 2008 Results		
Maryland HMO/POS Average	**80%**	
CIGNA	90%	★★★
BlueChoice	87%	★★★
Kaiser Permanente	84%	★★
Aetna	79%	★★
Coventry	78%	★★
OCI	71%	★
M.D. IPA	70%	★

Satisfaction with the Experience of Care
Plan Performance by Measure
(HMO/POS)

Rating of Health Plan, 2008 Results		
Maryland HMO/POS Average	**33%**	
CIGNA	38%	★★★
BlueChoice	36%	★★
M.D. IPA	34%	★★
Coventry	30%	★★
Kaiser Permanente	33%	★★
OCI	33%	★★
Aetna	25%	★

Health Plan Customer Service, 2008 Results		
Maryland HMO/POS Average	**51%**	
M.D. IPA	55%	★★★
Aetna	54%	★★
Coventry	54%	★★
CIGNA	52%	★★
OCI	52%	★★
Kaiser Permanente	45%	★
BlueChoice	41%	★

Getting Needed Care, 2008 Results		
Maryland HMO/POS Average	**45%**	
Coventry	52%	★★★
BlueChoice	46%	★★
CIGNA	45%	★★
OCI	45%	★★
Aetna	43%	★★
M.D. IPA	43%	★★
Kaiser Permanente	41%	★★

Getting Care Quickly, 2008 Results		
Maryland HMO/POS Average	**51%**	
CIGNA	57%	★★★
Coventry	54%	★★
OCI	52%	★★
BlueChoice	50%	★★
Aetna	49%	★★
M.D. IPA	49%	★★
Kaiser Permanente	45%	★

How Well Doctors Communicate, 2008 Results		
Maryland HMO/POS Average	**65%**	
Coventry	69%	★★
BlueChoice	66%	★★
Aetna	65%	★★
M.D. IPA	65%	★★
Kaiser Permanente	63%	★★
CIGNA	64%	★★
OCI	62%	★★

Rating of Health Care, 2008 Results		
Maryland HMO/POS Average	**39%**	
Coventry	45%	★★★
BlueChoice	43%	★★
Aetna	40%	★★
CIGNA	40%	★★
M.D. IPA	38%	★★
Kaiser Permanente	36%	★★
OCI	33%	★★

Satisfaction with the Experience of Care
Plan Performance by Measure
(HMO/POS)

Shared Decision Making, 2008 Results		
Maryland HMO/POS Average	**56%**	
Coventry	60%	★★
OCI	60%	★★
Aetna	55%	★★
CIGNA	55%	★★
M.D. IPA	55%	★★
Kaiser Permanente	54%	★★
BlueChoice	53%	★★

Health Promotion and Education, 2008 Results		
Maryland HMO/POS Average	**25%**	
CIGNA	27%	★★
OCI	27%	★★
Aetna	26%	★★
Coventry	26%	★★
BlueChoice	24%	★★
Kaiser Permanente	24%	★★
M.D. IPA	22%	★★

Coordination of Care, 2008 Results		
Maryland HMO/POS Average	**41%**	
Coventry	48%	★★★
OCI	43%	★★
BlueChoice	42%	★★
Kaiser Permanente	42%	★★
CIGNA	38%	★★
M.D. IPA	39%	★★
Aetna	37%	★★

Satisfaction with the Experience of Care
Plan Performance by Measure
(PPO)

Rating of Health Plan, 2008 Results		
Maryland PPO Average	**36%**	
Blue Preferred	48%	★★★
MAMSI Life	38%	★★
Aetna PPO	29%	★
CGLIC	29%	★

Health Plan Customer Service, 2008 Results		
Maryland PPO Average	**52%**	
MAMSI Life	59%	★★★
Blue Preferred	55%	★★
CGLIC	49%	★★
Aetna PPO	47%	★

Getting Needed Care, 2008 Results		
Maryland PPO Average	**45%**	
Blue Preferred	48%	★★
MAMSI Life	47%	★★
Aetna PPO	46%	★★
CGLIC	41%	★★

Getting Care Quickly, 2008 Results		
Maryland PPO Average	**56%**	
Blue Preferred	61%	★★★
MAMSI Life	61%	★★★
Aetna PPO	52%	★★
CGLIC	49%	★

How Well Doctors Communicate, 2008 Results		
Maryland PPO Average	**66%**	
Blue Preferred	70%	★★
MAMSI Life	70%	★★
Aetna PPO	64%	★★
CGLIC	60%	★

Rating of Health Care, 2008 Results		
Maryland PPO Average	**41%**	
Blue Preferred	46%	★★★
MAMSI Life	46%	★★★
Aetna PPO	36%	★
CGLIC	35%	★

Satisfaction with the Experience of Care
Plan Performance by Measure
(PPO)

Shared Decision Making, 2008 Results		
Maryland PPO Average	**55%**	
MAMSI Life	64%	★★★
Blue Preferred	56%	★★
Aetna PPO	52%	★★
CGLIC	47%	★

Health Promotion and Education, 2008 Results		
Maryland PPO Average	**26%**	
Blue Preferred	31%	★★★
MAMSI Life	27%	★★
Aetna PPO	26%	★★
CGLIC	21%	★

Coordination of Care, 2008 Results		
Maryland PPO Average	**40%**	
Blue Preferred	44%	★★
MAMSI Life	44%	★★
Aetna PPO	36%	★★
CGLIC	36%	★★

Behavioral Healthcare
Plan Performance by Measure
(HMO/POS)

Follow-up After Hospitalization for Mental Illness, 7 Days, 2008 Results		
Maryland HMO/POS Average	**54%**	
Kaiser Permanente	68%	★★★
BlueChoice	59%	★★★
M.D. IPA	56%	★★
OCI	54%	★★
Aetna	48%	★
CIGNA	48%	★
Coventry	46%	★

Follow-up After Hospitalization for Mental Illness, 30 Days, 2008 Results		
Maryland HMO/POS Average	**73%**	
Kaiser Permanente	80%	★★★
BlueChoice	78%	★★★
OCI	73%	★★
M.D. IPA	72%	★★
CIGNA	69%	★★
Coventry	69%	★★
Aetna	67%	★

Antidepressant Medication Management, Optimal Practitioner Contacts, 2008 Results		
Maryland HMO/POS Average	**19%**	
Kaiser Permanente	28%	★★★
Aetna	21%	★★
M.D. IPA	21%	★★
CIGNA	17%	★★
OCI	17%	★
BlueChoice	15%	★
Coventry	15%	★

Antidepressant Medication Management, Effective Acute Phase Treatment, 2008 Results		
Maryland HMO/POS Average	**64%**	
BlueChoice	69%	★★★
Aetna	67%	★★
CIGNA	64%	★★
Coventry	64%	★★
OCI	64%	★★
Kaiser Permanente	62%	★
M.D. IPA	60%	★

Antidepressant Medication Management, Effective Continuation Phase Treatment, 2008 Results		
Maryland HMO/POS Average	**48%**	
BlueChoice	54%	★★★
Aetna	50%	★★
CIGNA	48%	★★
Coventry	46%	★★
Kaiser Permanente	46%	★
M.D. IPA	46%	★★
OCI	46%	★★

Initiation of Alcohol and Other Drug (AOD) Dependence Treatment, 2008 Results		
Maryland HMO/POS Average	**49%**	
Kaiser Permanente	68%	★★★
Aetna	50%	★★
Coventry	48%	★★
CIGNA	47%	★★
M.D. IPA	46%	★★
OCI	43%	★
BlueChoice	35%	★

Behavioral Healthcare
Plan Performance by Measure
(HMO/POS)

Engagement of Alcohol and Other Drug Dependence Treatment, 2008 Results		
Maryland HMO/POS Average	**17%**	
BlueChoice	24%	★★★
Kaiser Permanente	22%	★★★
CIGNA	18%	★★
OCI	18%	★★
Aetna	16%	★
Coventry	13%	★
M.D. IPA	13%	★

Initiation of Follow-Up Care for Children Prescribed ADHD Medication, 2008 Results		
Maryland HMO/POS Average	**32%**	
M.D. IPA	39%	★★★
Aetna	37%	★★★
OCI	36%	★★★
CIGNA	32%	★★
BlueChoice	29%	★
Kaiser Permanente	28%	★
Coventry	25%	★

Continuation of Follow-Up Care for Children Prescribed ADHD Medication, 2008 Results		
Maryland HMO/POS Average	**45%**	
BlueChoice	87%	★★★
M.D. IPA	51%	★★
Kaiser Permanente	43%	★★
OCI	41%	★★
Aetna	39%	★★
CIGNA	32%	★
Coventry	23%	★

Behavioral Healthcare
Plan Performance by Measure
(PPO)

Follow-up After Hospitalization for Mental Illness, 7 Days, 2008 Results		
Maryland PPO Average	**46%**	
MAMSI Life	49%	★★
CGLIC	46%	★★
Aetna PPO	45%	★★
Blue Preferred	43%	★★

Follow-up After Hospitalization for Mental Illness, 30 Days, 2008 Results		
Maryland PPO Average	**64%**	
CGLIC	71%	★★★
MAMSI Life	66%	★★
Aetna PPO	63%	★★
Blue Preferred	56%	★

Antidepressant Medication Management, Optimal Practitioner Contacts, 2008 Results		
Maryland PPO Average	**23%**	
MAMSI Life	28%	★★★
Blue Preferred	22%	★★
Aetna PPO	21%	★★
CGLIC	19%	★★

Antidepressant Medication Management, Effective Acute Phase Treatment, 2008 Results		
Maryland PPO Average	**68%**	
MAMSI Life	72%	★★
CGLIC	68%	★★
Aetna PPO	66%	★★
Blue Preferred	66%	★★

Antidepressant Medication Management, Effective Continuation Phase Treatment, 2008 Results		
Maryland PPO Average	**54%**	
Blue Preferred	55%	★★
CGLIC	55%	★★
MAMSI Life	53%	★★
Aetna PPO	51%	★★

Health Plan Descriptive Information
Plan Performance by Measure
(HMO/POS)

Family Medicine Board Certified Practitioner, 2008 Results		
Maryland HMO/POS Average	**82%**	
Kaiser Permanente	93%	★★★
Coventry	87%	★★★
CIGNA	81%	★★
BlueChoice	79%	★
Aetna	71%	★
M.D. IPA	NR	NR
OCI	NR	NR

Internal Medicine Board Certified Practitioner, 2008 Results		
Maryland HMO/POS Average	**82%**	
Kaiser Permanente	93%	★★★
CIGNA	83%	★★★
Aetna	80%	★
BlueChoice	78%	★
Coventry	77%	★
M.D. IPA	NR	NR
OCI	NR	NR

OB/GYN Board Certification, 2008 Results		
Maryland HMO/POS Average	**76%**	
Kaiser Permanente	91%	★★★
CIGNA	76%	★★
BlueChoice	75%	★★
Coventry	70%	★
Aetna	68%	★
M.D. IPA	NR	NR
OCI	NR	NR

Pediatric Specialist Board Certification, 2008 Results		
Maryland HMO/POS Average	**84%**	
Kaiser Permanente	89%	★★★
CIGNA	85%	★★
Aetna	83%	★★
BlueChoice	81%	★
Coventry	81%	★
M.D. IPA	NR	NR
OCI	NR	NR

Other Specialist Board Certification, 2008 Results		
Maryland HMO/POS Average	**79%**	
Kaiser Permanente	88%	★★★
CIGNA	81%	★★★
Coventry	74%	★
Aetna	71%	★
BlueChoice	NR	NR
M.D. IPA	NR	NR
OCI	NR	NR

APPENDIX B:
METHODS FOR DATA ANALYSIS

METHODS FOR DATA ANALYSES

Methodology to Compare Plan Performance

For each HEDIS measure, CAHPS question, and CAHPS composite, a score is computed for each plan, and the mean value is computed for all of the plans as a group. Each score or mean is expressed as a percentage, with higher values representing more favorable performance.

Plan ratings for each measure are based on the difference between the plan score and the unweighted group mean. The statistical significance of each difference is determined by computing a 95 percent confidence interval (CI) around it. If the lower limit of the CI is greater than zero, then the plan score is significantly above the mean. If the upper limit of the CI is less than zero, then the plan score is significantly below the mean. Plans with scores significantly above or below the mean at the 95 percent significance level usually received the highest and lowest designations, respectively. All remaining plans received the middle designation.

The specific formula for calculating the CI for each measure is as follows.

For a given HEDIS measure or CAHPS individual question and plan k, let the difference d_k = plan k score – group mean. Then the formula for the 95 percent CI is $d_k \pm 1.96\sqrt{Var(d_k)}$

where $Var(d_k)$= Variance of d_k is estimated as

$$\frac{P(P-2)}{P^2} * \frac{p_k(1-p_k)}{n_k} + \frac{1}{P^2}\sum_{k=1}^{P}\frac{p_k(1-p_k)}{n_k}$$

and p_k = plan k score
P = total number of plans
n_k = the measure denominator for plan k

For a CAHPS composite, the variance formula is modified by substituting the plan composite global proportion variance ($CGPV_k$) for the $p_k(1-p_k)/n_k$ terms where $CGPV_k$ =

$$\frac{N}{N-1}\sum_{i=1}^{N}\left(\sum_{j=1}^{m}\frac{1}{m}\frac{(x_{ij}-\bar{x}_j)}{n_j}\right)^2$$

and $j = 1,\ldots,m$ questions in the composite measure
$i = 1,\ldots,n_j$ members responding to question j
x_{ij} = response of member i to question j (0 or 1)
$\bar{x}_j$ = plan mean for question j
N = members responding to at least one question in the composite.

Alternatively, the CI formula can be rearranged to compute the test statistic $\frac{d_k^2}{Var(d_k)}$.

For $d_j > 0$, the lower limit of the CI is > 0 if and only if $\frac{d_k^2}{Var(d_k)} > 1.96^2 = 3.84$.

For $d_j < 0$, the upper limit of the CI is < 0 if and only if $\frac{d_k^2}{Var(d_k)} > 1.96^2 = 3.84$.

Comparing Rates Across Years

For determining the statistical significance of the trend in a plan score between 2006 and 2008, first compute the difference in plan scores between the two years. This difference *d* can be written as $p_{2006} - p_{2008}$ where p_{200x} is the plan score for year 200x on a given measure. Then compute a 95% CI around the difference. If the lower limit of the CI is greater than zero then the trend is significantly upward. If the upper limit of the CI is less than zero then the trend is significantly downward.

The formula for the CI around *d* is: $d \pm 1.96\sqrt{Var(d)}$

where $Var(d) = \hat{p}(1-\hat{p})\left(\frac{1}{n_{2006}} + \frac{1}{n_{2008}}\right)$

and $\hat{p} = \frac{p_{2006}n_{2006} + p_{2008}n_{2008}}{n_{2006} + n_{2008}}$

and n_{200x} is the measure denominator for year 200x.

APPENDIX C:
METHODOLOGY FOR AUDIT OF HEDIS 2008 RATES FROM MARYLAND HMO/POS AND PPO PLANS

METHODOLOGY FOR AUDIT OF HEDIS 2008 RATES FROM MARYLAND HMO, POS, AND PPO PLANS

HEDIS Compliance Audit™

NCQA's HEDIS Compliance Audit has a standardized methodology that enables organizations to make direct comparison of plan rates for HEDIS performance measures. Maryland hired HealthcareData Company, LLC (HDC), an NCQA licensed organization, to conduct a full audit of the Maryland commercial health plans as prescribed by *HEDIS 2008, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*, published by NCQA. In addition, HDC reviewed non-HEDIS data that the MHCC required plans to report in 2008.

A major objective of the audit is to determine the reasonableness and accuracy of how each plan collects data for performance reporting in Maryland. In addition to ensuring that publicly reported rates are accurate and comparable, the audit also satisfies a requirement of NCQA Health Plan Accreditation.

HEDIS is a standardized set of key performance measures designed to gather information that purchasers and consumers need for reliable comparison of managed care plan performance. By using a standardized methodology to collect data and calculate measure results, consumers, government agencies, employers, and health plans can more accurately evaluate and trend plan performance and compare plans with each other. NCQA-Certified HEDIS Compliance auditors focus on two areas when evaluating each health plan, specifically: 1.) an assessment of the plan's overall information system (IS) capabilities; and 2.) an evaluation of the plan's ability to comply with HEDIS specifications for individual measures.

Audit Implementation

The audit process itself is divided into three phases: 1.) audit preparation; 2.) onsite visit; and 3.) post-onsite and reporting activities. During these phases, auditors focus on a number of performance areas, including information practices and control procedures, sampling methods, data integrity and analytic file production, algorithmic compliance with measurement specifications, reporting, and documentation. A detailed description of the well-defined phases of the audit appears in NCQA's *HEDIS 2008, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.*

Phase 1: Audit Preparation

The initial phase consists of various supporting tasks or activities defined by NCQA. A key activity critical to the audit's success is each organization's completion of the Baseline Assessment Tool (BAT) in a timely manner prior to the onsite visit, followed by a review of the completed tool by auditors and MHCC staff. The BAT is a comprehensive instrument designed by NCQA to collect information from the health plan regarding its structure, information processing (e.g., claim/encounter, medical record review, membership data, provider data), and HEDIS reporting procedures (e.g., measure programming/determinations, reporting functions).

For organizations not using an NCQA-certified software vendor, auditors also perform the key task of selecting a core set of measures for each plan. The protocol requires a minimum number of 15 measures (plus the CAHPS survey sample frame). Auditors use the core set to evaluate all measures within the various HEDIS domains; review findings are then extrapolated to the full set of HEDIS measures to make a final determination of reportability. As needed, the measure set can be expanded based on any finding or issue that surfaces during the onsite audit. Each auditor uses a variety of criteria to select the core set, which includes, but is not limited to, the following.

- Measures revised by NCQA from the prior year
- New measures being reported
- Measures calculated by vendors or by outside third parties
- Issues identified from review of the BAT that could impact code development
- Internal processes affecting data collection
- Problems experienced by the organization in prior audits

Source-code review for measures in the core set starts during Phase 1, beginning with review of the source code associated with the CAHPS sample frame programming.

Phase 2: Onsite Visit

During Phase 2, auditors conduct in-person interviews and record examination at the office of each plan. The onsite portion comprises a number of critical activities that fall into two broad categories: 1.) an assessment of compliance with NCQA's standards for information systems (IS) capabilities; and 2.) an evaluation of compliance with HEDIS measure specifications.

(1) IS Standards Assessment: Auditors determine the impact of various IS practices on the HEDIS reporting process. The key to accurate reporting is collecting comprehensive and accurate data. Auditors do not attempt to evaluate the overall effectiveness of the health plan's management of IS; rather, they determine whether the health plan's automated systems, information management practices, and data control procedures ensure that all information required for HEDIS reporting is adequately captured, translated, stored, analyzed, and reported.

(2) HEDIS Measure Determination Standards: Each measure has a detailed set of specifications that describes both its purpose and method of calculation. In this activity, auditors determine whether the processes used to produce each HEDIS measure comply with HEDIS specifications and yield reportable results. If issues or discrepancies are identified, the health plan is given the

opportunity to make corrections and resubmit corrected code until the auditors are satisfied that all specifications are met.

Phase 3: Post-Onsite and Reporting Activities

In Phase 3, auditors work closely with plan representatives to ensure that they understand all unresolved issues and deficiencies, as well as the potential effects of these matters on HEDIS data collection and reporting. When indicated, additional questions are presented to each plan about its software, programming, manual processing, and data input and output. Additionally, follow-up may become necessary to examine the effect of significant events, such as system conversion. Each plan is given a final review and the opportunity to correct unresolved items before a final determination on reportability is issued for each HEDIS measure. Key activities accomplished during this phase are as follows.

(1) Initial Report of Findings. Within 10 working days of the onsite visit, the audit team prepares an initial report on its visit. The report is returned to the health plan and includes the following components.

- A detailed list of any outstanding issues
- A list of all materials/documentation not yet received
- An assessment of whether each measure tested meets specific data requirements
- A list of all problem areas that require follow-up action before the final audit report is issued
- Potential problems with measure rate integrity
- Notes about any measures that, based on current findings, would receive a *Not Report (NR)* designation if no further action is taken to correct identified deficiencies

(2) Medical Record Review Validation. In this portion of the audit, auditors complete their evaluation of the health plan's medical record review process. They begin by reviewing all training materials and internal oversight policies established by the plan for medical record review. Next, auditors verify the accuracy of the health plan's findings in which a numerator-positive event was identified (i.e., the plan's reviewer determined whether or not the criteria for the measure were met and the designated medical service was delivered). Auditors select two measures for each plan and request 30 charts for each measure.

(3) IDSS Review. Health plans use the Interactive Data Submission System (IDSS) to record electronically all HEDIS results and calculations submitted to NCQA and MHCC. Maryland-specific data are submitted on an MHCC-specific data submission tool. The IDSS review consists of two phases. First, the plan submits results to NCQA, where data are subjected to a series of rules and guidelines that help identify potential problem areas for correction. After passing this level of review, plans inform the auditor of their readiness for final review. Auditors compare plan results to established NCQA benchmarks and the plan's rates from the previous year. Rates that vary by 10 percent or more between years are flagged, as are rates below the 10th and above the 90th percentiles, in comparison with NCQA benchmarks. Any problems detected are evaluated to determine whether additional analysis and review are necessary.

(4) Audit Designations. After reviewing all relevant documentation and processes, the auditor issues a designation of *Report (R)* or *Not Report (NR)* for each measure included in the audit. Determination for each measure is based on the rationales described here.

Report (R)

(R) indicates that the measure is fully or substantially compliant with HEDIS specifications or has only minor deviations that do not significantly bias the reported rate. Under NCQA guidelines, it is possible for subcomponents of a measure to fail the audit and be designated *NR* without resulting in an *NR* rating for the entire measure. An example of this is the *Ambulatory Care* measure, which comprises four subcategories: outpatient visits, emergency room visits, ambulatory surgery, and observation room stays. One of these subcategories could be designated *NR*, but the measure, being a composite of three other reportable subcategories, would be deemed *R*. A measure designation of *R* may also be assigned where the denominator for the measure is too small to report a valid rate or where the plan did not offer a health benefit for the measure being reported. In these cases, the *rate* is designated in the Maryland publications as *Not Applicable (NA)*.

Not Report (NR)

In compliance with guidelines established by the State of Maryland, the *NR* designation indicates that the rate submitted by a plan did not pass the audit. In other words, the auditor determined that the results produced by the plan were significantly biased and did not reflect the plan's true performance. NCQA has broader categories for the *NR* designation, but in Maryland, health plans may not voluntarily choose to accept an *NR* designation in place of a rate. Plans are required to calculate and report all HEDIS measures that are part of the State's mandated performance reporting process unless the measure is designated *NR* by the auditor.

(5) Audit Findings. HDC summarizes its audit findings in a plan-specific Final Audit Report that is submitted to the plan and to MHCC. The report includes recommendations for improvement and change in future audits.

APPENDIX D:
METHODOLOGY FOR ADMINISTERING THE CAHPS® 4.0H SURVEY TO MARYLAND HMO, POS, AND PPO PLAN MEMBERS

METHODOLOGY FOR ADMINISTERING THE CAHPS 4.0H SURVEY TO MARYLAND HMO, POS, AND PPO PLAN MEMBERS

Background

MHCC contracted with WB&A Market Research, an NCQA-certified survey vendor specializing in health care and other consumer satisfaction surveys, to conduct research on the satisfaction of plan members following standard CAHPS[7] procedures. In addition, MHCC contracted with the NCQA-licensed audit firm, HealthcareData Company, LLC to review programming code used to create the list of eligible members for the survey and to validate the integrity of the sample frame before WB&A drew the sample and administered the survey. Survey data collection began in mid-February 2008 and lasted into May 2008. Summary-level data files generated by NCQA were distributed in June to each plan for their review of data prior to signing their attestations.

Sample sizes remained stable in 2008, based on analysis of 2007 data. The sample size is set to achieve the minimum number (411) of completed surveys necessary to obtain reportable results.

In total, the core CAHPS survey consists of 59 questions. There are also 10 additional supplemental questions specifically for Maryland plans. The core of the CAHPS survey, which changed from the 3.0H version to the 4.0H version in 2007, is a set of 13 measures used to understand satisfaction with the experience of care, which include 4 ratings questions that reflect overall satisfaction and 7 multiquestion composites that summarize responses in key areas. Rating items ask respondents to rate their doctor, specialist, experience with all care, and health plan on a 0–10 scale. Responses are summarized into 3 categories: 9 or 10 belong to the top category, 7 or 8 belong to the second, and the remaining ratings fall into the third category.

Seven composite scores are generated from individual respondent-level data: Claims Processing, Customer Service, Getting Care Quickly, Getting Needed Care, How Well Doctors Communicate, Plan Information On Costs, and Shared Decision Making. In addition, question summary rates are also reported individually for two items summarizing health promotion and education and coordination of care.

Survey Methods and Procedures

Sampling: Eligibility and Selection Procedures

Health plan members who are eligible to participate in the CAHPS 4.0H adult commercial survey had to be 18 years of age or older as of December 31 of the measurement year (2007). They also had to be continuously enrolled in the commercial plan for at least 11 of the 12 months of 2007, and remain enrolled in the plan in 2008. Enrollment data sets submitted to the CAHPS vendor are sets of all eligible members—the relevant population. All health plans are required to

[7] CAHPS originally stood for the *Consumer Assessment of Health Plans Study*, but as the products evolved beyond health plans, the name changed to *Consumer Assessment of Healthcare Providers and Systems* to capture the full range of survey products and tools.

have their CAHPS data set (sample frame) audited by the licensed HEDIS auditor prior to sending it to the survey vendor.

The standard sample size for 2008 administration (2007 measurement year) included a 10 percent over-sample and was 1,210. To reach the maximum number of selected members, sample files were sent to a National Change of Address (NCOA) look-up and telephone matching service. Updated addresses and phone numbers were merged into the sample files.

Survey Protocol

The CAHPS survey protocol employs a rigorous, multistage contact protocol that features a mixed-mode methodology consisting of a four-wave mail process (two questionnaires and two reminder postcards), with at least six telephone follow-up attempts. This protocol is designed both to maximize response rates and to give different types of responders a chance to reply to the survey in a way that they find comfortable. For example, telephone responders are more likely to be younger, male, and healthier; mail responders are more likely to be older, better educated, and less healthy. The mail-only methodology is an option under the CAHPS protocol, but MHCC chose to use the mixed-mode methodology.

Response Rates

As directed by NCQA, the response rate is calculated by dividing the number of completed surveys by the number in the original sample minus the ineligible respondents (completes/total sample—ineligibles). A survey is classified as a valid completion if the member appropriately responds to one or more questions. Ineligible respondents are those who are no longer enrolled in the health plan, cannot respond to the survey in the language in which it is administered, are deceased, or are mentally or physically incapacitated.

There is no minimum required response rate, but there is a required minimum denominator of 100 responses to achieve a reportable rate. In 2008, the average response rate of the seven HMO plans was 38.5 percent; the highest response rate was 45.7 percent and the lowest was 33.1 percent. The average response rate of the four PPO plans was 36.1 percent; the highest response rate was 41.5 percent, and the lowest was 29.6 percent.